

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM#19b

State of Maryland / Department of Health and Mental Hygiene

97 04 001

Items: 10f, 17, 19a per F.H. G-744 2/14/97 re **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Diane Michelle Thompson				2. Date of Death Month Feb Day 8 Year 1997		3. Time of Death 8:40 AM		
	4a. Facility Name (If not institution, give street and number) Muddy Creek Road				4b. City, Town, or Location of Death Harwood		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 070 60 1992		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 22 Yrs.		8. Date of Birth (Month, Day, Year) Jul 10 1974 PA		
	10a. State Md		10b. County Anne Arundel		10c. City, Town or Location Churchton		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 1202 Garret Ave				10f. Zip Code 20732 20733		10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student Orthodontic Ass.		16b. Kind of Business/Industry Education Dental			
17. Father's Name (First, Middle, Last) Michael Goodrich Thompson				18. Mother's Name (First, Middle, Maiden Surname) Lisa Anne Kendall					
19a. Informant's Name/Relationship (Type, Print) Michael Thompson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20733 1202 Garret Ave., Churchton, Md 20732					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Zion Cemetery		20c. Location - City or Town, State Feb 12 1997 Lothian, Md		20d. Location - City or Town, State		
21. Signature of Funeral Service Licensee Kimberly S. Rome				22. Name and Address of Facility Hardesty Funeral Home P A 12 Ridgely Ave., Annapolis, Md 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. head injury Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death immediate	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year) Feb 8, 1997		28b. Time of Injury 8:40 A.M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Muddy Creek Road			28d. Describe how injury occurred motor vehicle accident						
28f. Location (Street and Number or Rural Route Number, City or Town, State) Anne Arundel Co.									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29c. License number D28640	
29b. Signature and title of certifier Jeffrey Suggs MD								29d. Date signed (Month, Day, Year) Feb. 8, 1997	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2011 Sentry Circle Apt 102 Odenton Md 21113									
31. Date filed (Month, Day, Year) FEB 11 1997								32. Registrar's Signature Julia Anderson-Randall	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04002

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA

TAYLOR

2. Date of Death

02 07 1997

3. Time of Death

7:40 AM

4a. Facility Name (If not institution, give street and number)

Magnolia Center

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George County

Funeral
Director

5. Social Security Number

216-09-1868

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept. 26, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George Co.

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6211 Kaybro Street

10f. Zip Code

20707

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

City of Baltimore

17. Father's Name (First, Middle, Last)

Lawrence

Unknown

Mallonee

18. Mother's Name (First, Middle, Maiden Surname)

Katherine

Unknown

Bruns

19a. Informant's Name/Relationship (Type, Print)

Kay David Taylor / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6211 Kaybro Street, Laurel, Maryland 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore Cemetery

Date

2/10/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Juanita R Thomas

22. Name and Address of Facility

John C. Miller, Inc.

6415 Belair Road, Baltimore, Maryland 21206

23a. Permit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George C. Hajjar, Jr., MD

29c. License number

039550

29d. Date signed (Month, Day, Year)

2/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md 20706

31. Date filed (Month, Day, Year)

FEB 11 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04003

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Francis A. Unkelbach

2. Date of Death

February 5, 1997

3. Time of Death

3:00PM

4a. Facility Name (If not institution, give street and number)

Overlea Garden Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-01-1302

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

August 15, 1917

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6505 Belle Vista Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Expidator

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Charles Unkelbach

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bauer

19a. Informant's Name/Relationship (Type, Print)

Helen Rita Unkelbach

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6505 Belle Vista Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garden of Faith Cemetery

Date

2/10/97

20c. Location - City or Town, State

Baltimore, Maryland 21206

21. Signature of Funeral Service Licensee

Manton J. Dippel

22. Name and Address of Facility

The Dippel Funeral Home Inc.
7110 Belair Road Baltimore, Maryland 2120623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Senile Dementia

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Benign Prostatic Hypertrophy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Manton J. Dippel

29c. License number

D14793

29d. Date signed (Month, Day, Year)

2/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9618 Belair Rd Baltimore Md 21236

31. Date filed (Month, Day, Year)

FEB 11 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04004

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theodore William von Eiff				2. Date of Death Month Day Year February 9 1997		3. Time of Death 9:40AM	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare				4b. City, Town, or Location of Death Parkville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 061-01-3072		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 9 1914	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Parkville	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 8710 Emge Rd.				10f. Zip Code 21234		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Vice President		16b. Kind of Business/Industry Insurance			
	17. Father's Name (First, Middle, Last) William L. von Eiff				18. Mother's Name (First, Middle, Maiden Surname) Amelia Weis			
	19a. Informant's Name/Relationship (Type, Print) Maruerita M. von Eiff/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30B Dunvale Rd. Towson, Md. 21204			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cold Spring Cemetery		20c. Location - City or Town, State 2-13-97 Cold Spring, New York			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Dementia Dua to (or as a consequence of): b. Dehydration Dua to (or as a consequence of): c. IHD Dua to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D41901		29d. Date signed (Month, Day, Year) 2/10/97		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Elad Mirza MD, 3007 E Northern, Baltimore, MD 21214								
31. Date filed (Month, Day, Year) FEB 11 1997				32. Registrar's Signature Julia Gordon-Rendell				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours of the death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04005

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maxine Walker				2. Date of Death Month Feb Day 11 Year 1997		3. Time of Death 7:18 A.M.	
	4a. Facility Name (If not institution, give street and number) Golden Age Guest Home				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 523-20-8230		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 20, 1917	
	9. Birthplace (State or Foreign Country) Colorado		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Sykesville	
To Be Completed by Funeral Director	Usual Residence of Decedent 10e. Street and Number 1442 Buckhorn Road				10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Procurement Officer		16b. Kind of Business/Industry United States Gov't	
	17. Father's Name (First, Middle, Last) Benjamin Onstott				18. Mother's Name (First, Middle, Maiden Surname) Carrie Unknown			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Carol J. Fitz				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2395 Mount Ventus Road #2 Manchester, MD 21102			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Union Highlands		20c. Location - City or Town, State 2/17 Florence, Colorado		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Stephen M Jenkins				22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Road Randallstown, MD 21133			
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Parkinson's Disease				Approximate Interval Between Onset and Death > 5 YRS			
To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Seizure				Due to (or as a consequence of): 3 YRS			
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Syncope				Due to (or as a consequence of): 1 YR			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Patrick Turner		29c. License number 020806		29d. Date signed (Month, Day, Year) 2/11/97	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Patrick Turner, MD 1425 Liberty Rd Eldersburg MD 21784				31. Date filed (Month, Day, Year) FEB 11 1997			
	32. Registrar's Signature Patrick Turner				33. State Registrar's Signature Patrick Turner			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04006

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

3

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Estelle Williams</i>				2. Date of Death Month <i>February</i> Day <i>9</i> Year <i>1997</i>		3. Time of Death <i>9:45 AM</i>	
4a. Facility Name (If not institution, give street and number) <i>Liberty Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death	
5. Social Security Number <i>250-38-9044</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>71</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>May 12 1926</i>	
9. Birthplace (State or Foreign Country) <i>South Carolina</i>							
Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>2703 Oswego Avenue</i>		10f. Zip Code <i>21215</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th grade</i>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic</i>		16b. Kind of Business/Industry <i>Private Duty</i>	
17. Father's Name (First, Middle, Last) <i>William Gamble</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Ella Chandler</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Roosevelt Bowens</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2703 Oswego Avenue</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>King Memorial Park</i>		Date		20c. Location - City or Town, State <i>Woodlawn, Md.</i>	
21. Signature of Funeral Service Licensee <i>Joseph R. Walters Jr.</i>				22. Name and Address of Facility <i>Unity Funeral Home</i> <i>108 W. North Avenue - Balto, Md. 21201</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Myocardial Infarction</i> Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. <i>Coronary Artery Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Approximate Interval Between Onset and Death <i>1 hour</i> <i>10y</i>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <i>N/A</i>		28b. Time of Injury <i>N/A</i> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred <i>N/A</i>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>N/A</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>N/A</i>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D3486</i>		29d. Date signed (Month, Day, Year) <i>2-9-97</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Daniel R Howard 1530 Bolton St. Baltimore, MD 21217</i>							
31. Date filed (Month, Day, Year) <i>FEB 11 1997</i>		32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04007

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ISAAC L. WILLIAMS				2. Date of Death Month Day Year February 7, 1997		3. Time of Death 1820p	
	4a. Facility Name (If not institution, give street and number) PERRY POINT VA HOSPITAL				4b. City, Town, or Location of Death PERRY POINT		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 214-64-8353		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT 10, 1955	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location BALTO			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 3601 W. FOREST PARK AVE				10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 4yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUS DRIVER		16b. Kind of Business/Industry TRANSPORTATION			
	17. Father's Name (First, Middle, Last) ISAAC WILLIAMS JR				18. Mother's Name (First, Middle, Maiden Surname) HAZEL JACKSON			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) HAZEL WILLIAMS				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 W. FOREST PARK AVE BALTO, MD 21216			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEM GARRISON FOREST VA		Date FEB 13 1997		20c. Location - City or Town, State OWINGS MILLS, MD	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) TX. CENTER			
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 2/7/97		28b. Time of Injury 1815 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital		28d. Describe how injury occurred self-inflicted gunshot					
	28f. Location (Street and Number or Rural Route Number, City or Town, State) Perry Point VA Hosp							
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <i>[Signature]</i> Dennis J. Chute MD				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 8, 1997	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) FEB 11 1997								
32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4+1

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04008

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL WALKER

2. Date of Death

February 4th 1997

3. Time of Death

6-20 PM

4a. Facility Name (If not institution, give street and number)

BON SECOURS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-24-4180

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR. 6 1931

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3205 GARRISON BLVD

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
BLACK15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

11th grade

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Health Aide

16b. Kind of Business/Industry

Social Service

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Gibson

19a. Informant's Name/Relationship (Type, Print)

Anthony Mable/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1804 N. Smallwood Street, Baltimore, Maryland

21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

KING MEMORIAL PARK

Date

2-11

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

H. G. Close

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H
1206 W. NORTH AVENUE23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Acute Myocardial INFARCTION

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

20 minutes

b.

Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

10 years

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration Pneumonia

Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Theron Alder m.d.

House officer

29c. License number

038993

29d. Date signed (Month, Day, Year)

February 5th 1997

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

Theron Alder m.d.

2000 W. Baltimore street Baltimore MD 21223

31. Date filed (Month, Day, Year)

FEB 11 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

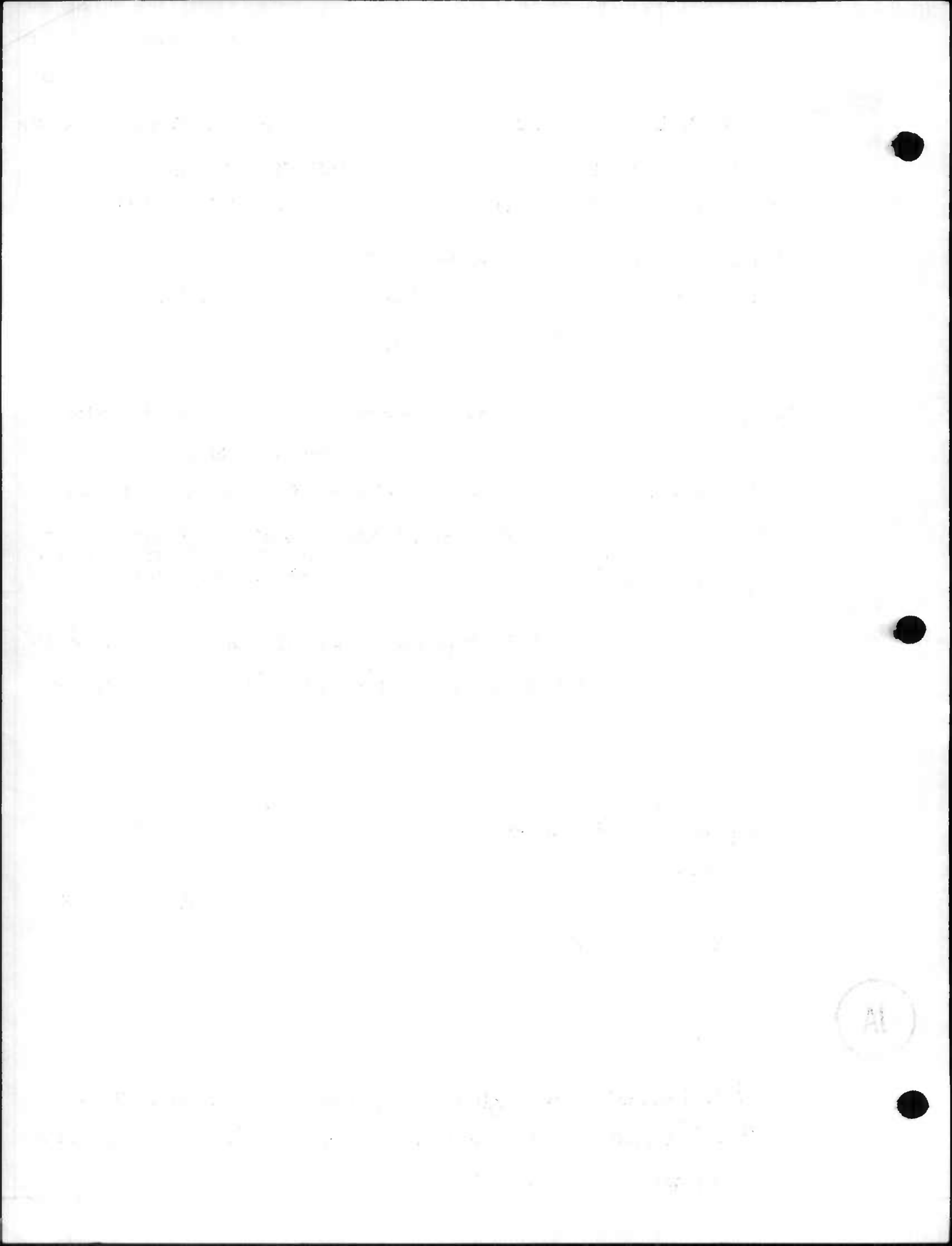
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 4 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04009

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

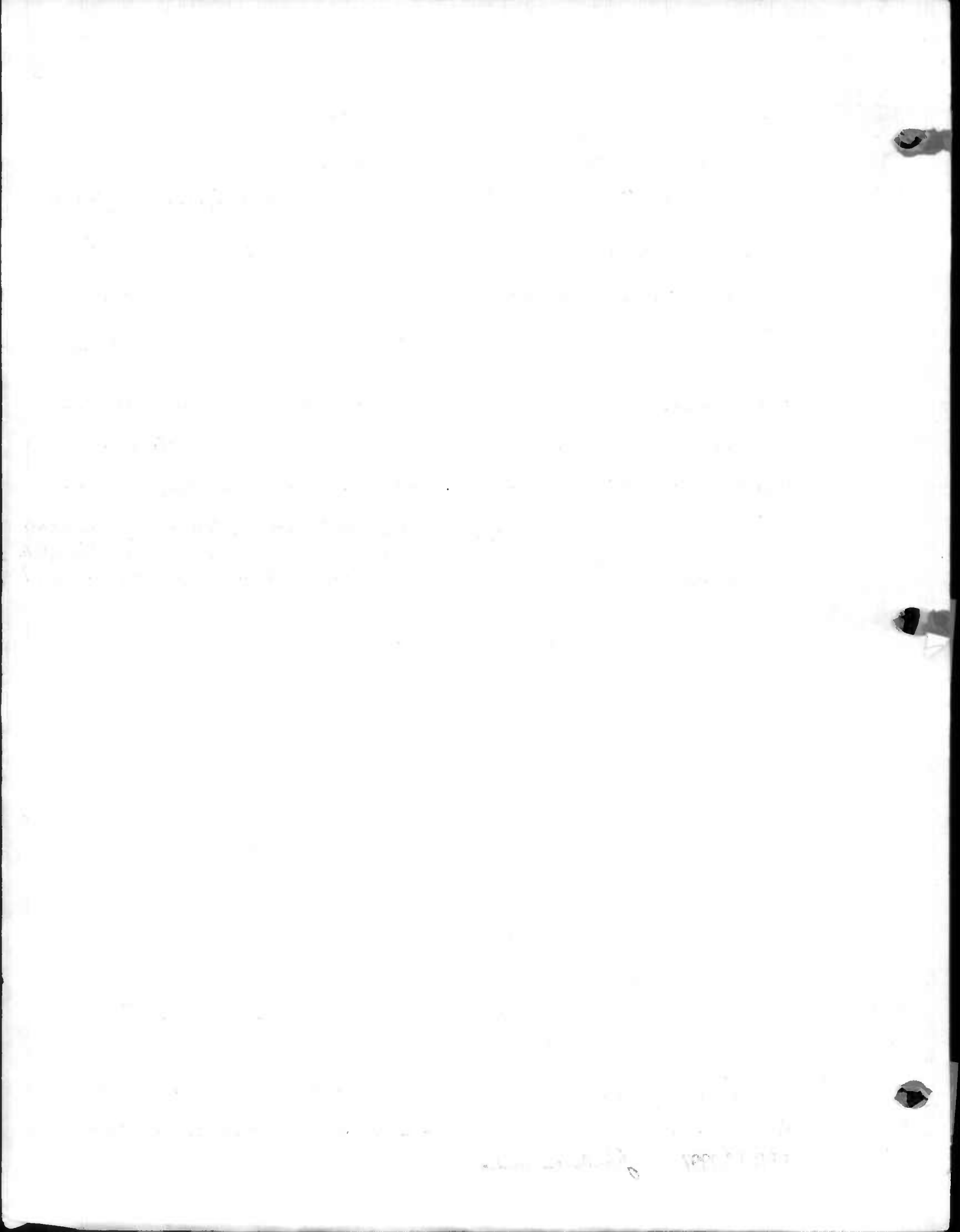
Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) DENNIS		2. Date of Death Month Day Year FEBRUARY 4, 1997		3. Time of Death 5:20 P.M.
4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
5. Social Security Number 218-84-6169	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	8. Date of Birth (Month, Day, Year) JUNE 7, 1967	9. Birthplace (State or Foreign Country) MARYLAND
Usual Residence of Decedent				
10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 3001 CHELSEA TERRACE		10f. Zip Code 21216		10g. Citizen of What Country? USA.
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+H-GRADE College (1-4 or 5+) College		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HANDY MAN		16b. Kind of Business/Industry SELF-EMPLOYED		
17. Father's Name (First, Middle, Last) JOHN WILBURN		18. Mother's Name (First, Middle, Maiden Surname) LILLIE GARRIS		
19a. Informant's Name/Relationship (Type, Print) ELIZABETH EVANS (SISTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4136 FAIRFAX ROAD, BALTIMORE, MD. 21216		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD. NATIONAL CEMETERY		20c. Location - City or Town, State 2-10-97 LAUREL, MARYLAND
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE., BALTIMORE, MD. 21217		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE NARCOTIC AND ETHANOL INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) FOUND 2-4-97		28b. Time of Injury FOUND 5:00 P M
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 3001 CHELSEA TERRACE BALTIMORE, MARYLAND		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 5, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) FEB 11 1997		32. Registrar's Signature 		

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item: 4a, per M.D G-744 2/10/97 reb

Item : 26 per M.D G-744 2/10/97 reb

Item: 5,19a per F.H. G-744 2/10/97 reb

Certificate of Death

Reg. No.

97 04010

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) CHARLES ZEILER		2. Date of Death Month 02 Day 03 Year 97		3. Time of Death 9:15am
4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview 6224 Eastern Ave.		4b. City, Town, or Location of Death Baltimore		4c. County of Death City
5. Social Security Number 214-52-8428	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 50 Yrs.	8. Date of Birth (Month, Day, Year) Aug. 7, 1946	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent				
10a. State Maryland	10b. County City	10c. City, Town or Location Baltimore City		10d. Inside City Limits X Yes 2 No
10e. Street and Number 6224 Eastern Avenue		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Funeral Director		16b. Kind of Business/Industry Funeral		
17. Father's Name (First, Middle, Last) Charles S. Zeiler		18. Mother's Name (First, Middle, Maiden Surname) Christine A. Gourlay		
19a. Informant's Name/Relationship (Type, Print) Mara Margaret Wittstadt		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Anna Lane Sykesville, MD 21784		
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cem		20c. Location - City or Town, State Feb 7 Baltimore, MD
21. Signature of Funeral Service Licensee Elizabeth Selinski		22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, MD 21224		

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sudden Death Due to (or as a consequence of): Dilated Cardiomyopathy Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HTN Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No	
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		25. Was case referred to medical examiner? 1 Yes 2 No	
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 Yes 2 No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier [Signature] M.D.		29c. License number D42908	
29d. Date signed (Month, Day, Year) 02-03-97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID S. SCHARFF M.D. 9 S. HIGHLAND AVE BALTO MD 21224	
31. Date filed (Month, Day, Year) FEB 10 1997		32. Registrar's Signature [Signature]	

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04011

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDITH V. ALSTON

2. Date of Death

FEBRUARY 8 1997

3. Time of Death

12:30am

Funeral
Director

4e. Facility Name (If not institution, give street and number)

62 SOUTH JENNINGS ROAD

4b. City, Town, or Location of Death

GLENBURNIE, Md. SEVERNAPARK

4c. County of Death

SEVERNAPARK

5. Social Security Number

213-16-5307

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1-22-1914

9. Birthplace (State or Foreign Country)

CALVERT CO.

Usual Residence of Decedent

10e. State

Md.

10b. County

ANNEARUNDEL

10c. City, Town or Location

SEVERNAPARK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

62 SOUTH JENNINGS ROAD

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6TH GRADE

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

MEDICAL

17. Father's Name (First, Middle, Last)

AUTHOR SEWELL CALVERTON

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

SHELIA ALSTON - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

62 SOUTH JENNINGS ROAD, SEVERNA PARK; A.A.CO.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND NATIONAL CEM 2-12

Date

20c. Location - City or Town, State

LAUREL, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

UNITY FUNERAL HOME

108 WEST NORTH AVENUE, BALTO. Md. 21201

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Fibrosis - Idiopathic

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State)

62 S. JENNINGS RD., A.A.CO

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 22483

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STUART JACOBS MD North Arundel Hospital Glen Burnie, Md 21061

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04012

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THEODORE

ALSTON

2. Date of Death

Month Day Year
FEB 09 1997

3. Time of Death

2:16 a

4a. Facility Name (If not institution, give street and number)

2400 BLK E. BIDDLE ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N.A

Funeral
Director

5. Social Security Number

214 86 8156

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

30 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
1-21-67

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State
Md.10b. County
N.A.

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

803 N. Chester St

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9th grade

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

LEROY ALSTON

18. Mother's Name (First, Middle, Maiden Surname)

SADIE ALSTON

19a. Informant's Name/Relationship (Type, Print)

DORA MAE MC KINNON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1011 Mc Donogh St. BALTO. Md. 21205

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Yoshell Cem.

Date

2/14/97

20c. Location - City or Town, State

BALTO. Md

21. Signature of Funeral Service Licensee

Joseph B. Roach Jr.

22. Name and Address of Facility

Locko Funeral Home 1304 N. Central Ave BALTO Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify) SCENE

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending Investigation 6 Could not be determined

28a. Date of Injury

(Month, Day, Year)
2/19/97

28b. Time of Injury

2:11 AM

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

subject shot

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number,
City or Town, State)2400 Blk E. Biddle St.
BALTIMORE, MD29a. Certifier
(Check only one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

FEBRUARY 09.1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

John Swanson-Rodriguez

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04013

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joe Dee ARCHER

2. Date of Death

February 11, 1997

3. Time of Death

4:02 A.M.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

215-30-6373

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

May 22, 1936

Tennessee

Usual Residence of Decedent

10e. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4425 Wynn Rd.

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 yrs.

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Lawrence Archer

18. Mother's Name (First, Middle, Maiden Surname)

Viola R. Hunley

19e. Informant's Name/Relationship (Type, Print)

M. Merlene Archer wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4425 Wynn Rd. Baltimore Md. 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Mem. Gardens 2-14

Date

20c. Location - City or Town, State

Bel Air

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk

7110 Sollers Point Rd. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-17041

29d. Date signed (Month, Day, Year)

12 FEB 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Marc I. Leavay MD 7600 Osler Drive Ste 315 Baltimore MD 21204

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

J. L. Harrison-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

97 04014

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lenore B. Binko				2. DATE OF DEATH MONTH February DAY 10 YEAR 1997		3. TIME OF DEATH 10:15 AM	
4. SOCIAL SECURITY NUMBER 213-28-0212		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 4, 1917	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) 9 Township Road		9b. CITY, TOWN OR LOCATION OF DEATH Dundalk	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Dundalk				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9 Township Road	
10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) August B. Klemm				18. MOTHER'S NAME (First, Middle, Maiden Surname) Olive Filbert			
19a. INFORMANT'S NAME (Type/Print) James B. Binko/Son				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Perlinton Road Timonium, MD 21093			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Pk. 2/13/1997		20c. LOCATION — City or Town, State Dorsey, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ISCHEMIC HEART DISEASE c. d. Approximate interval Between Onset and Death 1 DAY YEARS					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEGENERATIVE JOINT DISEASE						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D13664		29d. DATE SIGNED (Month, Day, Year) 2/10/97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. C. VENERACION JR M.D. PA . 1576 MERRITT BLVD, BALTO, MD 21202							
31. DATE FILED (Month, Day, Year) FEB 12 1997		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE ATTENDING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

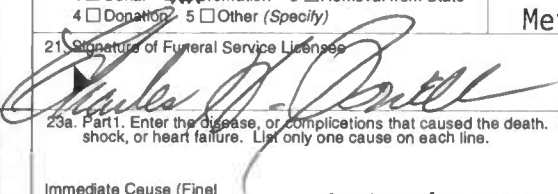
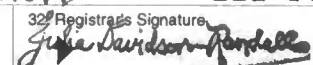
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04015

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN				2. Date of Death Month Day Year BOND FEBRUARY 7, 1997		3. Time of Death 3:47 P.M.	
	4a. Facility Name (If not institution, give street and number) 1510 MOSHER STREET				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-18-5350		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 22 1918	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1510 Mosher Street		10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Porter		16b. Kind of Business/Industry Lexington Market			
	17. Father's Name (First, Middle, Last) James Bond				18. Mother's Name (First, Middle, Maiden Surname) Ella Bond			
	19a. Informant's Name/Relationship (Type, Print) Camillus Jackson/Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 Rosedale Avenue Baltimore Maryland 21216			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Date 02/13		20d. Location - City or Town, State BALTIMORE, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. </div> <div style="width: 35%; border-left: 1px dashed black; padding-left: 5px;"> Approximate Interval Between Onset and Death </div> </div>							
	24a. Was an autopsy performed? INSPECTION <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  Dennis J. Chute M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 8, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) FEB 18 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04016

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James P. Blakely

2. Date of Death

February 09, 1997

Day Year

3. Time of Death

04:30

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

220 05 4721

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 11, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8419 Loch Raven Blvd.

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Hardware Store

17. Father's Name (First, Middle, Last)

George

Blakely

18. Mother's Name (First, Middle, Maiden Surname)

Magdalena

Guilda

19a. Informant's Name/Relationship (Type, Print)

Clara Lance / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8003 Chestnut Ave., Baltimore, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Crematory 2/11/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.

8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Pneumonia

Due to (or as a consequence of):

c.

Cerebrovascular accident

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Five days

Seven days

Seven days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Stuart M. Lubinski MD

29c. License number

DS0096

29d. Date signed (Month, Day, Year)

February 09, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stuart M. Lubinski MD - Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore MD

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Lina Davidson-Randall

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", "accident", "suicide", or "homicide",
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04017

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Albert Lyle Belt JR.

2. Date of Death

February 9 1997

Day

Year

3. Time of Death

2:35AM

4a. Facility Name (If not institution, give street and number)

Long View Nursing Home

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

212-24-6165

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 6, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Hampstead

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1139 S. Main St.

10f. Zip Code

21074

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Road Construction

17. Father's Name (First, Middle, Last)

Albert L. Belt, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ada W. Blizzard

19a. Informant's Name/Relationship (Type, Print)

May N. Belt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1139 S. Main St. Gen. Del. Hampstead, Md. 21074

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Mem. Gardens 02/12/97 Finksburg, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. H. Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel
3296 Charmil Dr., Manchester, Md. 21102

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Lung Cancer

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D33165

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Steven Shaffer 2111 Haver Pike Hampstead and 21074

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

J. H. Eckhardt

State
Registrar

Baltimore, Maryland 21215-0020

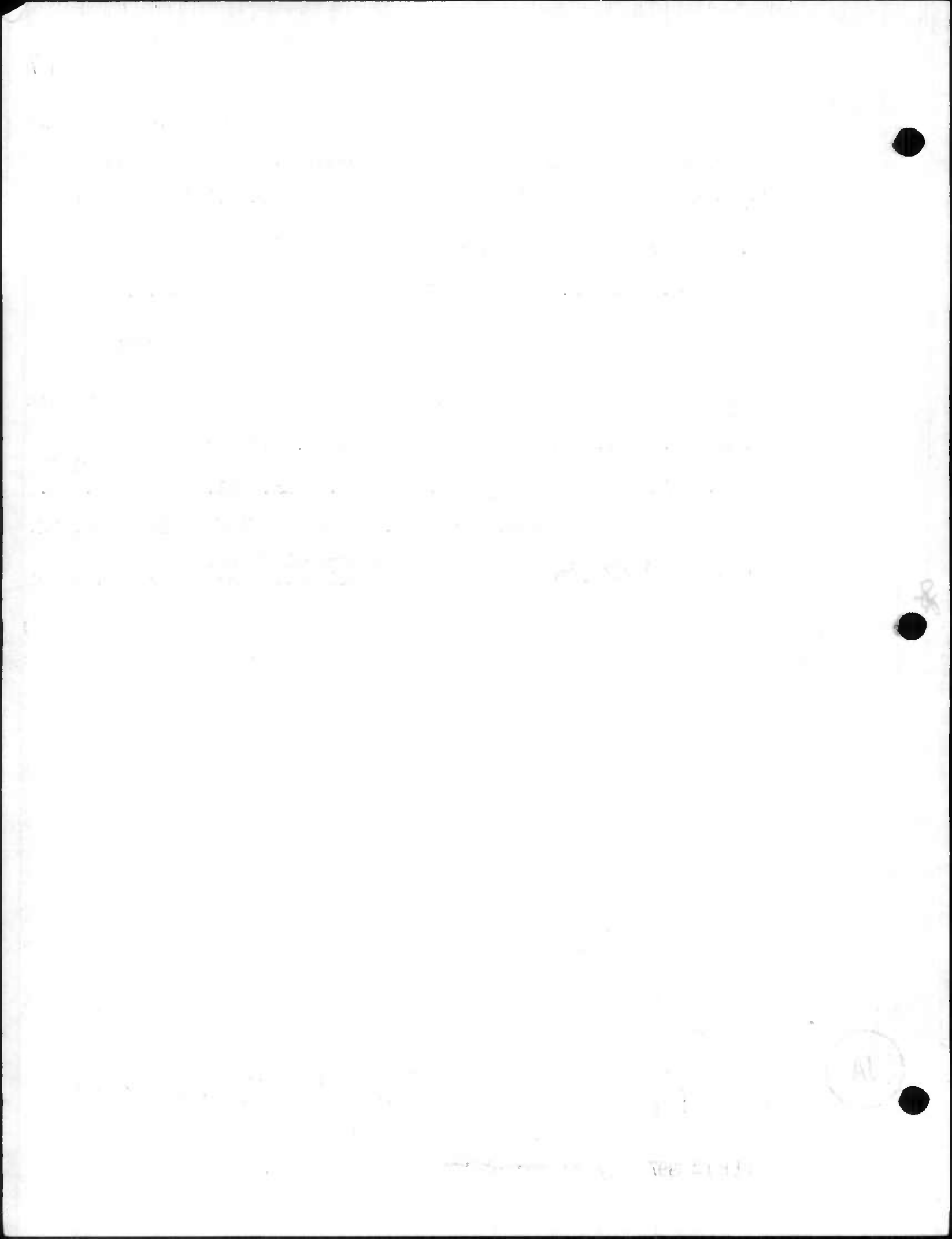
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04018

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles J. Burke

2. Date of Death
Month Day Year

2 7 97

3. Time of Death

8:42 PM

4a. Facility Name (If not institution, give street and number)

ST Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-01-6077

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12/19/1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 RUMFORD CORT#202

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief of Van & Motor Vehicles Balto. City

16b. Kind of Business/Industry

Public Works

17. Father's Name (First, Middle, Last)

Thomas Edward Burke

18. Mother's Name (First, Middle, Maiden Surname)

Mary Nueman

19a. Informant's Name/Relationship (Type, Print)

Vivian Burke/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Rumford Court # 202 Balto., MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

2/12/1997

20c. Location - City or Town, State

Maryland

21. Signature of Funeral Service Licensee

R. C. Witzke

22. Name and Address of Facility

Witzke Funeral Homes

1630 Edmondson Avenue Baltimore, Md 21228

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio-respiratory Arrest

Due to (or as a consequence of):

b. Massive Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric K. Shepard MD

29c. License number

D 47484

29d. Date signed (Month, Day, Year)

2/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ERIC K SHEPARD, MD ST Agnes Hospital 900 Caton Ave, Baltimore, MD

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

J. Wardson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PIERRE				2. Date of Death Month February Day 4 Year 1997				3. Time of Death 1:20 P.M.		
	4a. Facility Name (If not institution, give street and number) 7401 ASSATEAGUE DRIVE				4b. City, Town, or Location of Death SAVAGE				4c. County of Death HOWARD COUNTY		
Funeral Director	5. Social Security Number 218-56-5034		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) DEC 4, 1940		9. Birthplace (State or Foreign Country) CANADA		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State CANADA		10b. County PROVIDENCE OF QUEBEC		10c. City, Town or Location ST. CONSTANT, QUEBEC				10d. Inside City Limits 1 Yes 2 No		
	10e. Street and Number 187 CROISSANT STE. CATHERINE				10f. Zip Code J5A 1W1		10g. Citizen of What Country? CANADA				
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) 12TH GRADE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER				16b. Kind of Business/Industry TRANSPORTATION		
	17. Father's Name (First, Middle, Last) LORENZO BOURGON				18. Mother's Name (First, Middle, Maiden Surname) ALINE ST. DENIS						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CLAUDETTE BEAUDOIN BOURGON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 187 CROISSANT STE. CATHERINE-ST. CONSTANT, QUEBEC, CANADA						
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) 2/9/97 BROSSARD, QUEBEC, CANADA		20c. Location - City or Town, State						
	21. Signature of Funeral Service Licensee <i>Jackie H. Shannon</i>				22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229						
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
								24a. Was an autopsy performed? Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) MOTEL									
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dennis J. Chute MD</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) FEBRUARY 5, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS J. CHUTE MD. 111 Penn Street, Baltimore, Maryland 21201											
31. Data filed (Month, Day, Year) FEB 12 1997		32. Registrar's Signature <i>James Davidson-Randall</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transit certificate filed in by the funeral director.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04020

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Elizabeth June Crooks				2. Date of Death Month Day Year Feb 9, 1997		3. Time of Death 10:45pm	
4a. Facility Name (If not institution, give street and number) Baptist Home of Maryland				4b. City, Town, or Location of Death Owings Mills		4c. County of Death Baltimore	
5. Social Security Number 215-32-1856		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) June 3, 1910	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Cockeysville	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 17 Hickory Meadow Road		10f. Zip Code 21030		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Arthur V. Charshee				18. Mother's Name (First, Middle, Maiden Surname) Sadie Adelaide Hayden			
19a. Informant's Name/Relationship (Type, Print) Gordon L. Crooks, II/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Hickory Meadow Road, Cockeysville, MD 21030			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		20c. Location - City or Town, State Feb 11, Pikesville, Maryland		20d. Date 1997	
21. Signature of Funeral Service Licensed Bryan W. Clary		22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>arteriosclerotic cardiovascular disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's Disease</u>							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Howard B. Cohen, M.D.		29c. License number D21680		29d. Date signed (Month, Day, Year) February 11, 1997			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Cohen, M.D. 6717 Park Heights Ave., Baltimore, MD 21215							
31. Date filed (Month, Day, Year) FEB 12 1997		32. Registrar's Signature Purdson-Randall					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04021

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Regina Margaret Clark

2. Date of Death

Month Day Year
Feb. 8, 1997

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

College Manor Nursing Home

4b. City, Town, or Location of Death

LUTHERVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

215-32-4689

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 29, 1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State
MARYLAND10b. County
BALTIMORE10c. City, Town or Location
TIMONIUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 Brooking Court Unit 302

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

Investment

17. Father's Name (First, Middle, Last)

Morris Robert Abicht

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Regina Hogan

19a. Informant's Name/Relationship (Type, Print)

William H. Clark/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Brooking Court, Unit 302, Timonium, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Druid Ridge Cemetery

Date

11 FEB

20c. Location - City or Town, State

Pikesville, MD

21. Signature of Funeral Service Licensee

Victor Lengrand, Jr.

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Brain cancer

Approximate
Interval Between
Onset and Death

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

College Manor

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Timothy Souweine, M.D.

29c. License number

024732

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Timothy Souweine, M.D., Suite 300, Clinical Assocs. 515 Fairmount Ave. 21204

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

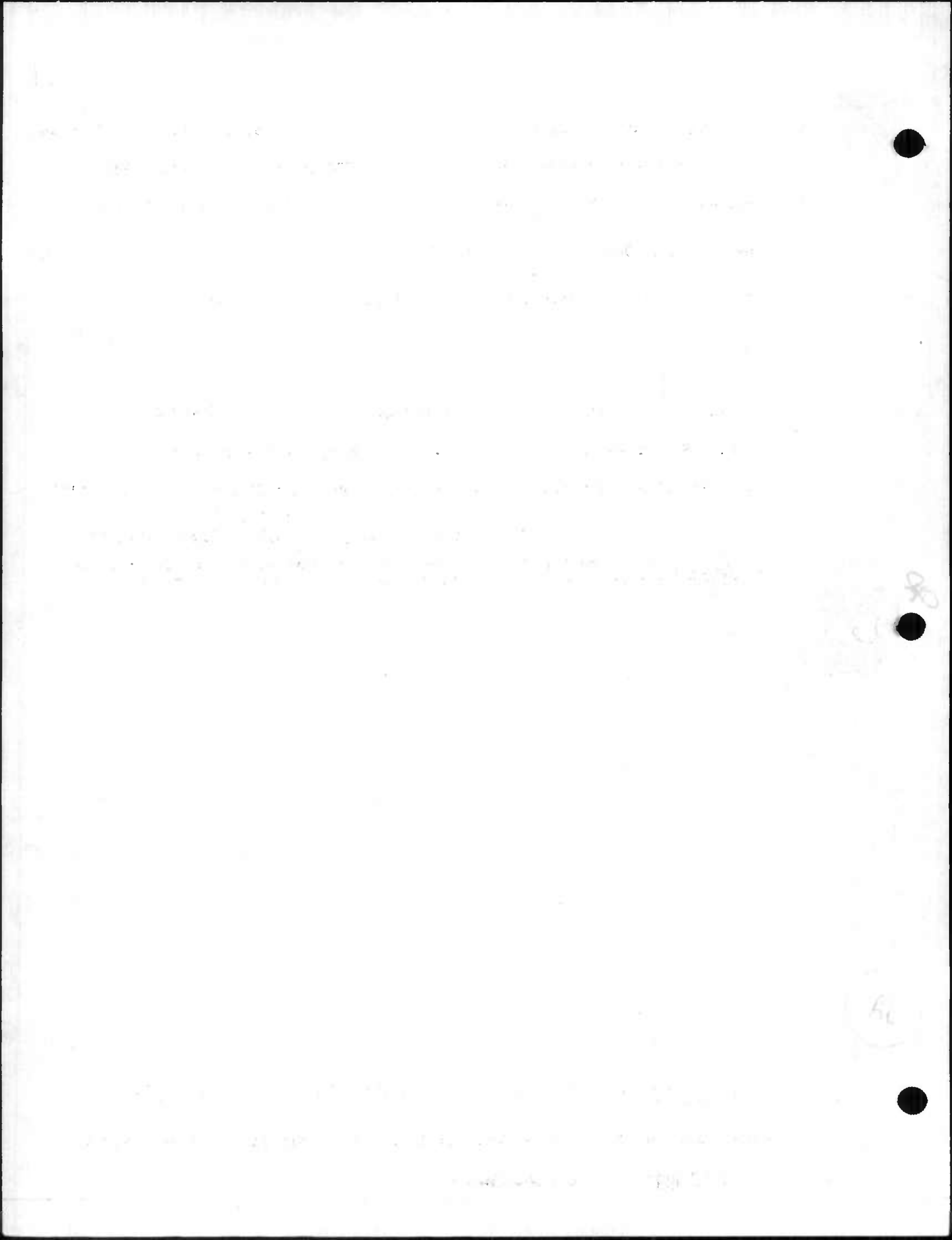
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04022

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLENNIE CONYERS

2. Date of Death

Month FEB, 7 Day 1997 Year

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTO. CITY

Funeral
Director

5. Social Security Number

228 32 9047

6. Sex

M 2 F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

8/4/27

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTO. CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

4127 FAIRFAX ROAD

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11/52
If Yes, Give Year or Dates: 7/54

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FOLK LIFT OPERATOR

16b. Kind of Business/Industry

ADDISON CLARK CO.

17. Father's Name (First, Middle, Last)

SAM CONYERS

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE CONYERS

19a. Informant's Name/Relationship (Type, Print)

ALICE PAULINE CONYERS WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4127 FAIRFAX RD. BALTIMORE MD. 21216

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST 2/12/97

Date

20c. Location - City or Town, State

OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee

Gail A. Doty

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac Dysrhythmia
Due to (or as a consequence of):b. Cardiovascular disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Asthma
Seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?
1 Yes 2 No

Hospital: 1 Inpatient 2 Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Charles Fortenberry M.D.

29c. License number

D46151

29d. Date signed (Month, Day, Year)

February 7, 1997

30. Name and address of person who completed cause of death. (Item 23a) (Type, Print)

P. R. Charles Fortenberry, Liberty Medical Center, 2600 Liberty Heights

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

A. Davidson-Hendall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04023

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Lillian Novella Curtian				2. Date of Death Month FEB. Day 10, Year 1997		3. Time of Death 7:52pm							
4a. Facility Name (If not Institution, give street and number) 3703 Century Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore							
5. Social Security Number 579-36-1158		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) April 14, 1928							
9. Birthplace (State or Foreign Country) Maryland													
Usual Residence of Decedent													
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number 3703 Century Avenue				10f. Zip Code 21227		10g. Citizen of What Country? USA							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Receptionist		16b. Kind of Business/Industry Jewelry Industry							
17. Father's Name (First, Middle, Last) Harlan Handy				18. Mother's Name (First, Middle, Maiden Surname) Mattie Unknown									
19a. Informant's Name/Relationship (Type, Print) Deborah A. Bowling/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3703 Century Avenue Baltimore, MD 21227									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		20c. Location - City or Town, State 2/14/97 Eldersburg, MD									
21. Signature of Funeral Service Licensee Dawn F. McDonald				22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Baltimore, MD 21228									
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Small Cell Cancer of Lung Due to (or as a consequence of):</td> <td rowspan="4"> Approximate Interval Between Onset and Death 1 yr </td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Small Cell Cancer of Lung Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 yr	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Small Cell Cancer of Lung Due to (or as a consequence of):	Approximate Interval Between Onset and Death 1 yr											
	b. Due to (or as a consequence of):												
	c. Due to (or as a consequence of):												
	d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier Paul Gormley MD				29c. License number D15587		29d. Date signed (Month, Day, Year) Feb 11 1997							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Gormley MD 900 EASON AVE BALTO MD 21229													
31. Date filed (Month, Day, Year) FEB 12 1997				32. Registrar's Signature Gina Davidson-Randall									

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

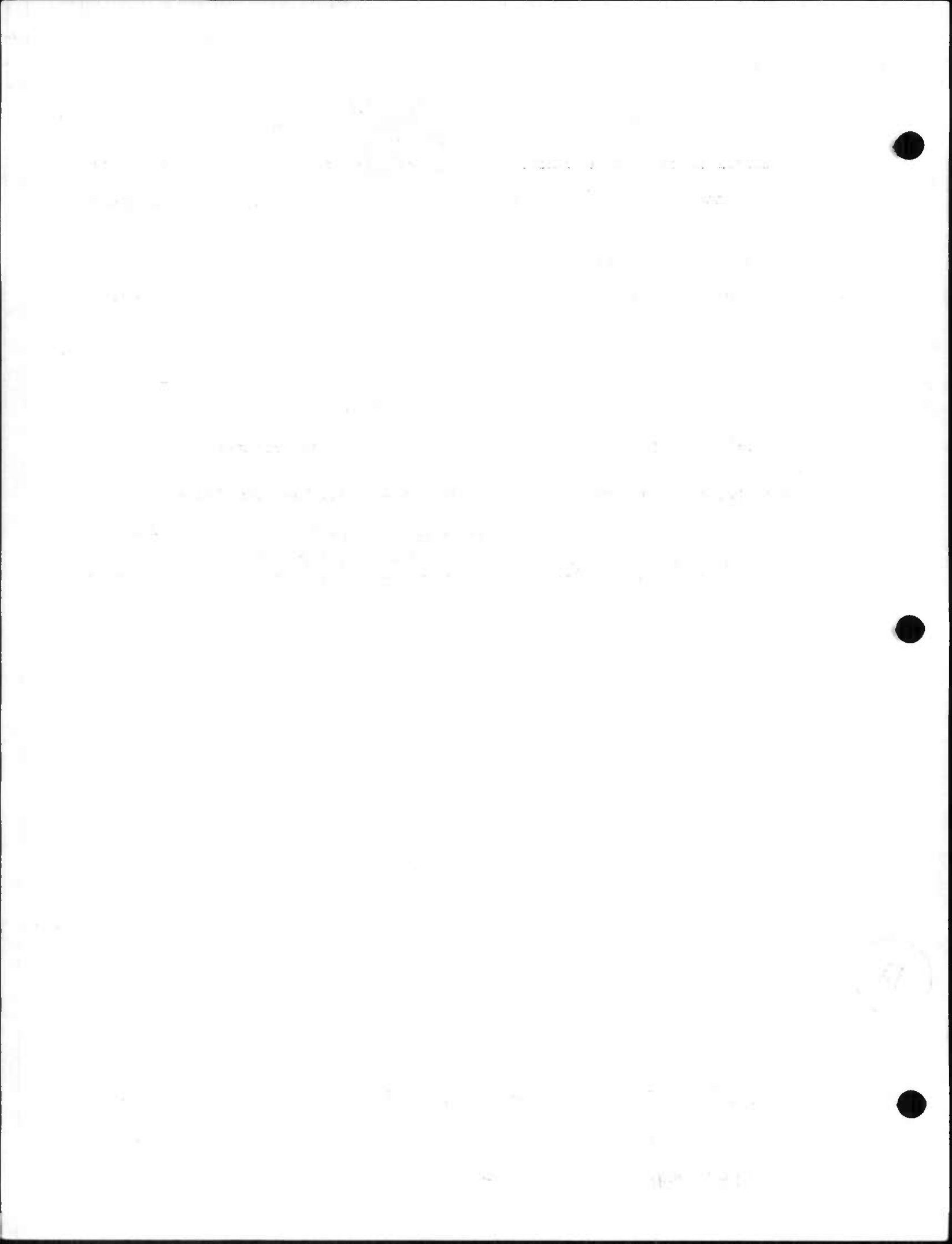
State of Maryland / Department of Health and Mental Hygiene

97 04025

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARA B. CORBIN		2. Date of Death Month FEB. Day 10 Year 1997		3. Time of Death 8:18PM
	4a. Facility Name (If not institution, give street and number) Chesapeake Health Care Center		4b. City, Town, or Location of Death Arnold		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 219-26-3508	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 2, 1907		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Anne Arundel
	10c. City, Town or Location Pasadena		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 7 Nicholson Road		10f. Zip Code 21122		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse
	17. Father's Name (First, Middle, Last) Charles A. Blaney		18. Mother's Name (First, Middle, Maiden Surname) Emma Wagner Harman		19. Kind of Business/Industry Health Care
	19a. Informant's Name/Relationship (Type, Print) Helen Herndon/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Nicholson Rd. Pasadena, MD 21122		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery Feb. 12, 1997		20c. Location - City or Town, State Woodlawn, MD
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061		
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death): Congestive Heart Failure Due to (or as a consequence of): Chronic Coronary Artery Disease Due to (or as a consequence of): Arteriosclerosis Due to (or as a consequence of): Malnutrition Due to (or as a consequence of): Vascular Dementia		Approximate Interval Between Onset and Death 2 Days 2 Years		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Vascular Dementia		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier William M. Attending Doctor		29c. License number D21684	
29d. Date signed (Month, Day, Year) 2-11-97		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CV. CYRIAC-MO 8109 Ritchie HWY, PASADENA, MD 21122			
31. Date filed (Month, Day, Year) FEB 12 1997		32. Registrar's Signature <i>[Signature]</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04026

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WENDELL DAVIS						2. Date of Death Month FEBRUARY Day 10 Year 1997		3. Time of Death 1:00 P.M.	
	4a. Facility Name (If not Institution, give street and number) VAMHCS FORT HOWARD DIVISION						4b. City, Town, or Location of Death FORT HOWARD		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 216-18-0539		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 22 1925		9. Birthplace (State or Foreign Country) SOUTH CAROLINA	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location ESSEX				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 1401 Maple Avenue				10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1943/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian			16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Charles Davis						18. Mother's Name (First, Middle, Maiden Surname) Minnie Green				
19a. Informant's Name/Relationship (Type, Print) Caroline M. Davis/Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Maple Avenue, Baltimore, Maryland 21221				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST VETERAN 2-14-97			20c. Location - City or Town, State OWINGS MILLS, MARYLAND				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death YEARS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier Aurora C. Tan, M.D.			29c. License number D14958		29d. Date signed (Month, Day, Year) 2/10/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AURORA C. TAN, M.D. -- 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052										
31. Date filed (Month, Day, Year) FEB 18 1997										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04027

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUMMIE

DAVIS, JR.

2. Date of Death

Month

Day

3. Time of Death

FEBRUARY 06 1997

7:55 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4005 W. COLDSRING LANE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

243-26-8315

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

12-9-1929

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State
Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4005 W. Coldspring Lane

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 8/1951
If Yes, Give Year or Dates: 7-22-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

NA

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Baltimore Gas & Electric

17. Father's Name (First, Middle, Last)

Lummie Davis, Sr

18. Mother's Name (First, Middle, Maiden Surname)

Gladys

19a. Informant's Name/Relationship (Type, Print)

Pamela Davis - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1933 Mitchville Road Bowie, Md 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Vet

Date

2-12-97

20c. Location - City or Town, State

Owings Mills, Md

21. Signature of Funeral Service Licensee

W. E. Edmond

22. Name and Address of Facility

March 15 H. West
4300 Wabash Avenue Baltimore 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE RENAL DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

Inspection
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accidental 6 ☐ Could not be determined
3 ☐ Suicidal 4 ☐ Homicidal

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Margarita Korell M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBRUARY 06 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04028

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE FOWLER DARNALL, SR.		2. Date of Death Month FEBRUARY Day 6 Year 1997		3. Time of Death 5:50 AM
	4a. Facility Name (If not Institution, give street and number) SAINT JOSEPH MEDICAL CENTER		4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 217-09-2397	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Oct. 12, 1912		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 4124 India Avenue		10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade Collage (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		
	17. Father's Name (First, Middle, Last) Joseph F. Darnall		18. Mother's Name (First, Middle, Maiden Surname) Dora T. Weaver		
	19a. Informant's Name/Relationship (Type, Print) Janet Dorrough (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4124 India Avenue, Baltimore, MD 21236		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Location - City or Town, State 2/10/97 Baltimore, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE MYOCARDIAL INFARCTION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE SEPSIS					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) M					
28b. Time of Injury M					
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 					
29c. License number D 37254					
29d. Date signed (Month, Day, Year) 2/8/97					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204					
31. Date filed (Month, Day, Year) FEB 12 1997					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04029

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred C. Dett				2. Date of Death Month Day Year Feb. 10, 1997		3. Time of Death 1:58 PM				
	4a. Facility Name (If not institution, give street and number) 308 Bond Ave.				4b. City, Town, or Location of Death Reisterstown		4c. County of Death Baltimore				
Funeral Director	5. Social Security Number 219-22-9751		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) April 2, 1924		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10a. State Md.		10b. County Baltimore		10c. City, Town or Location Reisterstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number 308 Bond Ave.				10f. Zip Code 21136		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Homemaker				
	17. Father's Name (First, Middle, Last) John H. Clark				18. Mother's Name (First, Middle, Maiden Surname) Mamie Branson						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Alverta Jones				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Brookebury Drive Apt 1B, Reisterstown, Md. 21136						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem. Feb. 12, 1997 Owings Mills, Md.		20c. Location - City or Town, State		20d. Date				
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee H. J. Eckhardt				22. Name and Address of Facility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certificate (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier E. P. Williamson EMD		29c. License number 211171		29d. Date signed (Month, Day, Year) February 11, 1997						
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. P. Williamson II 405 Frederick Ave CATONSVILLE				31. Date filed (Month, Day, Year) FEB 12 1997				32. Registrar's Signature John Davidson-Randall		
	31. Date filed (Month, Day, Year) FEB 12 1997				32. Registrar's Signature John Davidson-Randall				21228 Md.		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04030

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Robert A. Duea</i>				2. Date of Death Month <i>2</i> Day <i>8</i> Year <i>97</i>		3. Time of Death <i>1935</i>	
	4a. Facility Name (If not institution, give street and number) <i>6334 Cedar Lane</i>				4b. City, Town, or Location of Death <i>Columbia, MD</i>		4c. County of Death <i>Howard</i>	
Funeral Director	5. Social Security Number <i>470 284 133</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>67</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>2/17/30</i>	
	9. Birthplace (State or Foreign Country)		10a. State <i>Maryland</i>		10b. County <i>Howard</i>		10c. City, Town or Location <i>Fulton</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>11857 Rt 216, P.O. Box 537</i>		10f. Zip Code <i>20759</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>Korea</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Traffic Analyst</i>		16b. Kind of Business/Industry <i>Federal Government</i>			
	17. Father's Name (First, Middle, Last) <i>Arnold Duea</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Nora M. Danielson</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Dawn Duea (Wife)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11857 Rt 216, P.O. Box 537 Fulton, Maryland 20759</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Meadowridge Memorial Park</i>		20c. Date <i>Feb. 12, 1997</i>		20d. Location - City or Town, State <i>Dorsey, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>Robert Eugene Baker</i>				22. Name and Address of Facility <i>Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Sepsis</i> Due to (or as a consequence of): b. <i>Stroke</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>1 week</i> <i>8 months</i>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>William Flowers MD</i>				29c. License number <i>D20789</i>		29d. Date signed (Month, Day, Year) <i>Feb 10, 1997</i>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>William Flowers MD 11055 Little Patuxent Columbia MD</i>							
	31. Date filed (Month, Day, Year) <i>FEB 12 1997</i>				32. Registrar's Signature <i>John Davidson-Randall</i>			
	State Registrar							

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

1933



(A1)



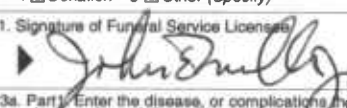
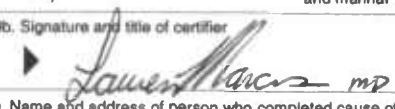
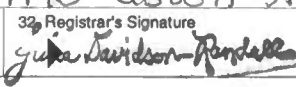
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04032

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ira N. ELLIOTT JR.				2. Date of Death Month Day Year February 6 1997		3. Time of Death 11:20 am						
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A						
Funeral Director	5. Social Security Number 212-28-2521		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 27, 1932	9. Birthplace (State or Foreign Country) Maryland					
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Md.	10b. County Baltimore	10c. City, Town or Location Dundalk			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10e. Street and Number 3423 McShane Way			10f. Zip Code 21222		10g. Citizen of What Country? USA							
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor		16b. Kind of Business/Industry Plumbing/Heating						
	17. Father's Name (First, Middle, Last) Ira Nelson Elliott Sr.				18. Mother's Name (First, Middle, Maiden Surname) Hertha May Hersler								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jeff Elliott son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 Erwin Drive Joppatown Md. 21085									
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Data 2-8	20c. Location - City or Town, State Baltimore						
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Congestive Heart Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Cardiomyopathy</td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	Approximate Interval Between Onset and Death	b. Cardiomyopathy	c. _____
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	Approximate Interval Between Onset and Death											
	b. Cardiomyopathy												
	c. _____												
	d. _____												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred								
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier  Lauren Marcus MD				29c. License number 96009		29d. Date signed (Month, Day, Year) February 6, 1997							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lauren Marcus 4940 Eastern Ave Baltimore, MD 21224													
31. Date filed (Month, Day, Year) FEB 12 1997		32. Registrar's Signature  Julie Davidson-Randall											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: When this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04033

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALMY ELLIOTT				2. Date of Death Month Day Year FEBRUARY 10, 1992		3. Time of Death 12:15 AM	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 215-09-5991		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 04/10/1912	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD.		10b. County Baltimore		10c. City, Town or Location Catonsville	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 424 Oak Court		10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Inspector		16b. Kind of Business/Industry Post Office			
	17. Father's Name (First, Middle, Last) John E. Elliott				18. Mother's Name (First, Middle, Maiden Surname) Mary Norfolk			
	19a. Informant's Name/Relationship (Type, Print) Diane M. Smith/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7783 C Street Chesapeake Beach, MD. 20732			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cem. Garrison Forest Vet.		20c. Location - City or Town, State 2/12/97 Owings Mills, MD.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Sterling Ashton Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD. 21228			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 1 week
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HERPES ZOSTER DEMENTIA							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D44505		29d. Date signed (Month, Day, Year) Feb 10, 1992		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) A J IMPERIAL JR - St. Agnes Hosp								
31. Date filed (Month, Day, Year) FEB 12 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97 04034

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04035

Certificate of Death

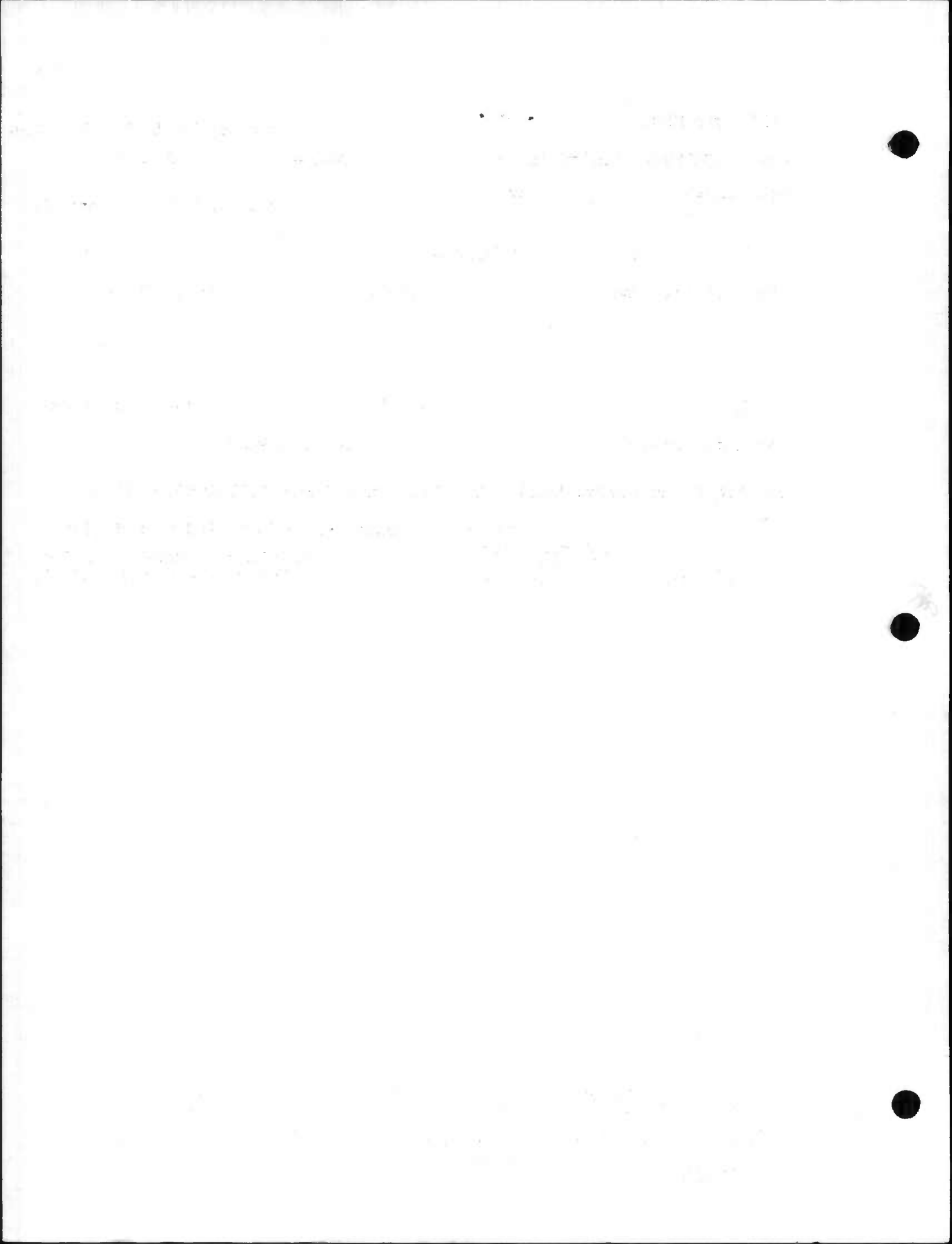
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Julia Anna Finke				2. Date of Death Month Day Year February 10, 1997		3. Time of Death 2:20 P.M.	
	4a. Facility Name (If not Institution, give street and number) Greater Baltimore Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore Co.	
Funeral Director	5. Social Security Number 213-14-3654		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 05, 1919	
	9. Birthplace (State or Foreign Country) Baltimore, Md.		10. Usual Residence of Decedent 10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1435 Meridene Drive		10f. Zip Code 21239		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Baltimore Co. Library			
	17. Father's Name (First, Middle, Last) John Henry Linmer				18. Mother's Name (First, Middle, Maiden Surname) Anna M. Deckwar			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Judy A. Dunaway (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Blake Drive Forest Hill, Maryland 21050			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cem.		20c. Date 02/14/97		20d. Location - City or Town, State Baltimore, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Jeffrey L. Gair				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 10 years</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier James A. Riddick				29c. License number J 05761		29d. Date signed (Month, Day, Year) 2/11/97	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) James A. Riddick, 7401 Aster Dr., Towson, MD 21204							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) FEB 12 1997				32. Registrar's Signature [Signature]			
	33. Registrar's Name [Name]							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene

97 04036

Item 1 2-18-97 Film G744 W.H.Per Doctor

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARGYRO FOKIANOS Fokianou						2. Date of Death Month Day Year February 6, 1997		3. Time of Death 2:30 P.M.	
	4a. Facility Name (If not institution, give street and number) 7516 Riddle Avenue						4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-94-1030		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 24, 1905		9. Birthplace (State or Foreign Country) Greece	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 7516 Riddle Avenue				10f. Zip Code 21224		10g. Citizen of What Country? Greece			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own home		
	17. Father's Name (First, Middle, Last) John Mereos						18. Mother's Name (First, Middle, Maiden Surname) Angerou Galanou			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Helen Sarikas, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7516 Riddle Ave., Baltimore, Md. 21224					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 2-10-97		20c. Location - City or Town, State Baltimore, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Aspiration pneumonia</u> Due to (or as a consequence of): b. <u>Dementia</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D43732		29d. Date signed (Month, Day, Year) February 7, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Harper, MD 5505 Hopkins Bayview Circle, Baltimore, MD 21224										
31. Date filed (Month, Day, Year) FEB 12 1997										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

97 04037

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <u>Johanna Fischl</u>				2. Date of Death Month <u>February</u> Day <u>9</u> Year <u>1997</u>				3. Time of Death <u>5:25 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Charlottesville Care Center</u>				4b. City, Town, or Location of Death <u>Catonsville</u>				4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>220-30-3305</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>89</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>OCT 24, 1907</u>		9. Birthplace (State or Foreign Country) <u>Germany</u>	
	Usual Residence of Decedant		10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Catonsville</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <u>713 Maiden Choice Ln., # 1302</u>				10f. Zip Code <u>21228</u>				10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> Collage (14 or 5+) <u></u>				16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>				16b. Kind of Business/Industry <u>Home</u>	
	17. Father's Name (First, Middle, Last) <u>Ferdinand Zachmeier</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Theresa Egelmeier</u>					
	19a. Informant's Name/Relationship (Type, Print) <u>August Zachmeier / Nephew</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>309 Foster Knoll Drive Joppa, MD 21085</u>					
Physician /Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory, Inc.</u>		Date <u>02/11/97</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>			
	21. Signature of Funeral Service Licensee <u>George E. MacNabb</u>		22. Name and Address of Facility <u>MacNabb Funeral Home, P.A.</u> <u>301 Frederick Road Balto., MD 21228</u>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Malignant Pleural Effusion</u> Dua to (or as a consequence of): b. <u>Endometrial Carcinoma</u> Dua to (or as a consequence of): c. <u></u> Dua to (or as a consequence of): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <u>weeks</u> <u>months</u>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D47447</u>		29d. Date signed (Month, Day, Year) <u>February 9, 1997</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Andrew Lazris 711 Maiden Choice Lane Catonsville Maryland</u>										
31. Date filed (Month, Day, Year) <u>FEB 12 1997</u>		32. Registrar's Signature <u>[Signature]</u>								

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04038

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rosa Frances Grooms

2. Date of Death

February 9, 1997

3. Time of Death

4:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Genesis Heritage Nursing Home

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

5. Social Security Number

213-32-9812

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 27, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

103 Center Place Apt. 326

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Oxenham

18. Mother's Name (First, Middle, Maiden Surname)

Anna Roe

19a. Informant's Name/Relationship (Type, Print)

Catherine F. Eckenrode/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8918 Mavis Avenue Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem. Park Cem. 2/13/97

Date

20c. Location - City or Town, State

Parkville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MELASTASTIC CARCINOMA OF BREAST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

SARINDER K TULSI MD

29c. License number

D27188

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SARINDER K TULSI, 103 Center Place Baltimore MD 21222

31. Date filed (Month, Day, Year)

FEB 12 1997

Funeral Director's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

AL

97 04039

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Corine Coiles</i>				2. DATE OF DEATH MONTH <i>02</i> DAY <i>05</i> YEAR <i>97</i>		3. TIME OF DEATH <i>0615</i> A M	
4. SOCIAL SECURITY NUMBER <i>220-05-1636</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>77</i> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____	7. DATE OF BIRTH (Month, Day, Year) <i>JAN. 14 1919</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Manor Care Health Services</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>ROSEDALE</i>	
9c. COUNTY OF DEATH <i>BALTIMORE CO.</i>				RESIDENCE OF DECEDENT			
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>HARFORD CO.</i>		10c. CITY, TOWN OR LOCATION <i>DARLINGTON</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1203 HOLLOWAY ROAD</i>				10f. ZIP CODE <i>21034</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th grade</i> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>DOMESTIC</i>		16b. KIND OF BUSINESS/INDUSTRY <i>PRIVATE HOMES</i>	
17. FATHER'S NAME (First, Middle, Last) <i>ALEXANDER GILES</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>IDA MAE GILES</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Rev. John Brown Jr./Guardian</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1604 Browns Road, Essex, Maryland 21221</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Berkley Cemetery</i>		DATE <i>2/8</i>		20c. LOCATION — City or Town, State <i>Darlington, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Brown</i>				22. NAME AND ADDRESS OF FACILITY <i>WILLIAM C. BROWN COMM. F/H 1206 W. NORTH AVENUE</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Congestive heart failure exacerbation</i>					
		b. <i>Ischemic and Dilated Cardiomyopathy</i>					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. _____					
		d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DM, Hypothyroidism, Severe Osteoporosis, CVA, Anemia.</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alonso MD</i>				29c. LICENSE NUMBER <i>D-38754</i>		29d. DATE SIGNED (Month, Day, Year) <i>2-5-97</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MALIKA WASEEM. 100 N. BROADWAY. BALTIMORE, MD - 21231</i>							
31. DATE FILED (Month, Day, Year) <i>FEB 12 1997</i>		32. REGISTRAR'S SIGNATURE <i>John Brown</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04040

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William S. Goodman

2. Date of Death

Month

Day

Year

February 10 1997

3. Time of Death

105AM

4a. Facility Name (If not institution, give street and number)

Gilcrest Hospice of Baltimore

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

578 16 3877

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

April 21, 1925

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Shadyside

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4925 Dogwood Rd

10f. Zip Code

20764

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give WW II Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automobile Comp.

17. Father's Name (First, Middle, Last)

Donald

18. Mother's Name (First, Middle, Maiden Surname)

Goodman

Katherine

Omahundra

19a. Informant's Name/Relationship (Type, Print)

Sharon Myers / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4925 Dogwood Rd., Shadyside, MD 20764

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

2/11/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann P.A.

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Small cell carcinoma of prostate

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify)

Hospice

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. A. Riley, M.D.

29c. License number

D25205

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed certificate of death (Item 29a) (Type, Print)

W. A. Riley, M.D. 6701 N. Charles St. Balto. MD 21205

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21201-0020

permit. Pages 1 and 2 should be filed within 2 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

M

84

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04041

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jethro

Green

2. Date of Death

Month Day Year
February 9, 1997

3. Time of Death

3 12/PM

4a. Facility Name (If not institution, give street and number)

JOSEPH RICHIE HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

250-16-0602

8. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 26, 1913

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3820 McDONOGH ST.

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFR. AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNKNOWN

16b. Kind of Business/Industry

UNKNOWN

17. Father's Name (First, Middle, Last)

JETHRO GREEN SR.

18. Mother's Name (First, Middle, Maiden Surname)

CARTHA GREEN

19a. Informant's Name/Relationship (Type, Print)

PAULETTE WHITEHEAD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3820 McDONOGH ST. BALTO. MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEM. FEB. 14, 1997

Date

20c. Location - City or Town, State

BALTO MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.
1300 EUTAW PLACE BALTIMORE MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of prostate

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20+ years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

obstructive uropathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Richey

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Hospice

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas Powell M.D.

29c. License number

D 13006

29d. Date signed (Month, Day, Year)

10 Feb 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Powell 101 W. Read St. Baltimore 21201

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Gordon-Rodale

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To be Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To be Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04042

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Charles Andrew Galton

2. Date of Death

February 9, 1997

3. Time of Death

4:15 AM

4a. Facility Name (If not institution, give street and number)

2515 Karylou Drive

4b. City, Town, or Location of Death

Kingsville

4c. County of Death

Harford

5. Social Security Number

219-18-9934

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 28, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2515 Karylou Drive

10f. Zip Code

21087

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tool and Die Maker

16b. Kind of Business/Industry

Machinery

17. Father's Name (First, Middle, Last)

James Galton

18. Mother's Name (First, Middle, Maiden Surname)

Marie Ritter

19a. Informant's Name/Relationship (Type, Print)

Mrs. Joan Galton (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2515 Karylou Drive, Kingsville, MD 21087

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Michael Luth Ch. Cem.

Date

2/11/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

NON SMALL CELL LUNG CANCER

Approximate Interval Between Onset and Death

5 YEARS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31775

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joan P. Edwards 2112 Bel Air Rd, Suite 4A Fallston, MD 21047

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Rondella

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04043

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BLANCHE A. GRIFFITH				2. Date of Death Month Day Year FEBRUARY 10, 1997		3. Time of Death 9:15 AM	
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 215-03-0340		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT 10, 1905	9. Birthplace (State or Foreign Country) PIKESVILLE, MD
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 406 S. GILMOR STREET				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6TH GRADE College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MILLING MACHINIST		16b. Kind of Business/Industry KOPPERS CO.		
17. Father's Name (First, Middle, Last) GEORGE WASHINGTON ALLENDER					18. Mother's Name (First, Middle, Maiden Surname) EMILY ROBERTS			
19a. Informant's Name/Relationship (Type, Print) OLIVER GRIFFITH (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 FOUNTAIN DRIVE-LINTHICUM HEIGHTS, MD 21090				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		Date 2/13/97		20c. Location - City or Town, State BALTIMORE		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SEPSIS Due to (or as a consequence of): b. VENTRICULAR ARRHYTHMIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PSEUDOMEMBRANOUS COLITIS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  MD		29c. License number D43977		29d. Date signed (Month, Day, Year) February 10 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CYNTHIA OLETHUS, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061								
31. Date filed (Month, Day, Year) FEB 12 1997				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04044

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Arthur Holsey, Sr.				2. Date of Death Month Day Year February 8, 1997		3. Time of Death 6:45 PM	
	4e. Facility Name (If not institution, give street and number) 111 Oak Avenue				4b. City, Town, or Location of Death Edgemere		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-22-4380		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) June 25, 1928	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Edgemere	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2428 Eugene Avenue		10f. Zip Code 21219	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) G.E.D. College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Building Instructor				16b. Kind of Business/Industry Home Building			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Edward Arthur Holsey				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Lufrio			
	19a. Informant's Name/Relationship (Type, Print) Rose Marie Holsey/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2428 Eugene Avenue Edgemere, Maryland 21219			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cem.		20c. Location - City or Town, State Dundalk, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Glioblastoma Multiforme Due to (or as a consequence of):				Approximate Interval Between Onset and Death 6 wks.			
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
	29c. License number D19423				29d. Date signed (Month, Day, Year) 2/10/97			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd 21223							
	31. Date filed (Month, Day, Year) FEB 12 1997				32. Registrar's Signature 			

AL)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04045

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wallace Lee Havener

2. Date of Death

February 10 1997

Day Year

3. Time of Death

6:50pm

4a. Facility Name (If not institution, give street and number)

Gilchrist 6601 North Charles Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

495-18-2748

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

75

8. Date of Birth (Month, Day, Year)

Aug. 11, 1921

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

109 Charmuth Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Railroad Industry

17. Father's Name (First, Middle, Last)

Robert Lee Havener

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Estelle Otte

19a. Informant's Name/Relationship (Type, Print)

Evelyn Ann Havener - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 Charmutt Rd., Timonium, MD 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gar.

Date

Feb. 13, 1997

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Lowell M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley
10 Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic colon cancer

Approximate Interval Between Onset and Death

1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify)

26. Place of Death (Check only one)

Hospice

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

NA

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. A. Riley, M.D.

29c. License number

D25205

29d. Date signed (Month, Day, Year)

February 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W. A. Riley, M.D. PPE Suite 203

6565 N. Charles St. Baltto, md 2120x

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04046

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) ALBERT L. HAWKINS SR.				2. Date of Death Month Day Year 2 - 4 - 1997		3. Time of Death 9:50 AM	
4a. Facility Name (If not institution, give street and number) (HOME) 2000 ODELL AVE. APT.623				4b. City, Town, or Location of Death BALTO.		4c. County of Death N/A	
5. Social Security Number 215-32-1569		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8-5-1935	
9. Birthplace (State or Foreign Country) MD							
Usual Residence of Decedent							
10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 2000 ODELL AVE. APT.623				10f. Zip Code 21237		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFR.AMERICAN	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry MISTY HARBORS			
17. Father's Name (First, Middle, Last) ROBERT HAWKINS				18. Mother's Name (First, Middle, Maiden Surname) ALBERTA FLEMING			
19a. Informant's Name/Relationship (Type, Print) ROBERTA JONES (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1708 DUNDALK AVE. BALTO. MD APT.A2			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEM. FEBRUARY 11, 1997		Date FEBRUARY 11, 1997		20c. Location - City or Town, State BALTI. MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ESTEPBROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. myocardial infarction Due to (or as a consequence of): b. coronary artery disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Rodney Brookins, MD				29c. License number D43636		29d. Date signed (Month, Day, Year) 2/10/97	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3411 Bank St. Balto, MD 21224							
31. Date filed (Month, Day, Year) FEB 12 1997				32. Registrar's Signature 			



(2)

100-100000-100

100-100000-100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 10c 2-12-97 Film G744 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

97 04047

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN HUTCHINS				2. Date of Death Month Day Year February 06 1997		3. Time of Death 4:45 am	
	4a. Facility Name (If not Institution, give street and number) BON SECOURS Hospital				4b. City, Town, or Location of Death BALTO MD		4c. County of Death N. A	
Funeral Director	5. Social Security Number 213 18 3474	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 21 2 1903	9. Birthplace (State or Foreign Country) Pa.	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County N. A.	10c. City, Town or Location Baltimore City 1825 W. LANVALE ST.			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1825 W. LANVALE ST		10f. Zip Code 21217		10g. Citizen of What Country? U.S.A			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) POWELL				18. Mother's Name (First, Middle, Maiden Surname) Katie			
	19a. Informant's Name/Relationship (Type, Print) Bergetta Archer				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ZIP Code) 2905 E. Coldspring Lane BALTO. MD 21214			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS Mem. PK		Date 21/01/97	20c. Location - City or Town, State Artimus. Md		
	21. Signature of Funeral Service Licensee Joseph B. Locks Jr.		22. Name and Address of Facility Locks Funeral Home 1304 N. Central Ave BALTO MD 21202					
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) Respiratory Failure						1 day	
	Due to (or as a consequence of): Pneumonia						2 days	
	Due to (or as a consequence of): Congestive Heart Failure						1 yr	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease Renal Failure							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how Injury occurred			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Laur		29c. License number D25044		29d. Date signed (Month, Day, Year) 2/7/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. R. H. M. D.								
31. Date filed (Month, Day, Year) FEB 12 1997		32. Registrar's Signature W. J. R. R. R.						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97 04048

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) INGRID HOWARD				2. DATE OF DEATH MONTH February DAY 4 YEAR 1997				3. TIME OF DEATH 4:30 PM	
4. SOCIAL SECURITY NUMBER 215-86-0210		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 28 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) 04-02-68				8. BIRTHPLACE (State or Foreign Country) Md.					
9a. FACILITY NAME (If not institution, give street and number) Bayview				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1119 N. Broadway				10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher Aide				16b. KIND OF BUSINESS/INDUSTRY Jonestown Daycare	
17. FATHER'S NAME (First, Middle, Last) Brince Lindsey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Joyce Delores Howard					
19a. INFORMANT'S NAME (Type/Print) Hazel M. Howard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1119 N. Broadway, Balt., MD 21213					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cem 2-10-97				20c. LOCATION — City or Town, State Catonsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Elvira M. Davis</i>				22. NAME AND ADDRESS OF FACILITY March F.H. EAST 1101 E. North Ave					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →				a. PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY				Approximate interval Between Onset and Death 6 MOS	
Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				b. RETROVIRAL INFECTION				8 YRS	
				c. _____					
				d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Queldun</i>				29c. LICENSE NUMBER 950217				29d. DATE SIGNED (Month, Day, Year) 2-5-97	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EMILY J. ERBELDING, MD. CARNEGIE 3, 600 N. WOLFE ST, BALT. 21207									
31. DATE FILED (Month, Day, Year) FEB 12 1997				32. REGISTRAR'S SIGNATURE <i>Gene Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04049

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIA HATZINICOLAS

2. Date of Death

Month Day Year
February 10, 1997

3. Time of Death

9:50 A.M.

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-58-4552D

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 5, 1918

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9503 Perry Brook Court

10f. Zip Code

21234

10g. Citizen of What Country?

Greece

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
2

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Michael Minatsi

18. Mother's Name (First, Middle, Maiden Surname)

Sofia Orfanou

19a. Informant's Name/Relationship (Type, Print)

Manuel Mastromanolis, Son-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9503 Perry Brook Court, Baltimore, Md. 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

2-13-97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Ann S. Matthews

22. Name and Address of Facility

Matthews Funeral Home

3021 Eastern Ave., Baltimore, Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

N/A

28b. Time of Injury

N/A

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Samuel Rodriquez

29c. License number

D34952

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5444 BELAIR ROAD BALTIMORE MARYLAND 21206

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

William Randall

State
Registrar

Baltimore, Maryland 21215-0020

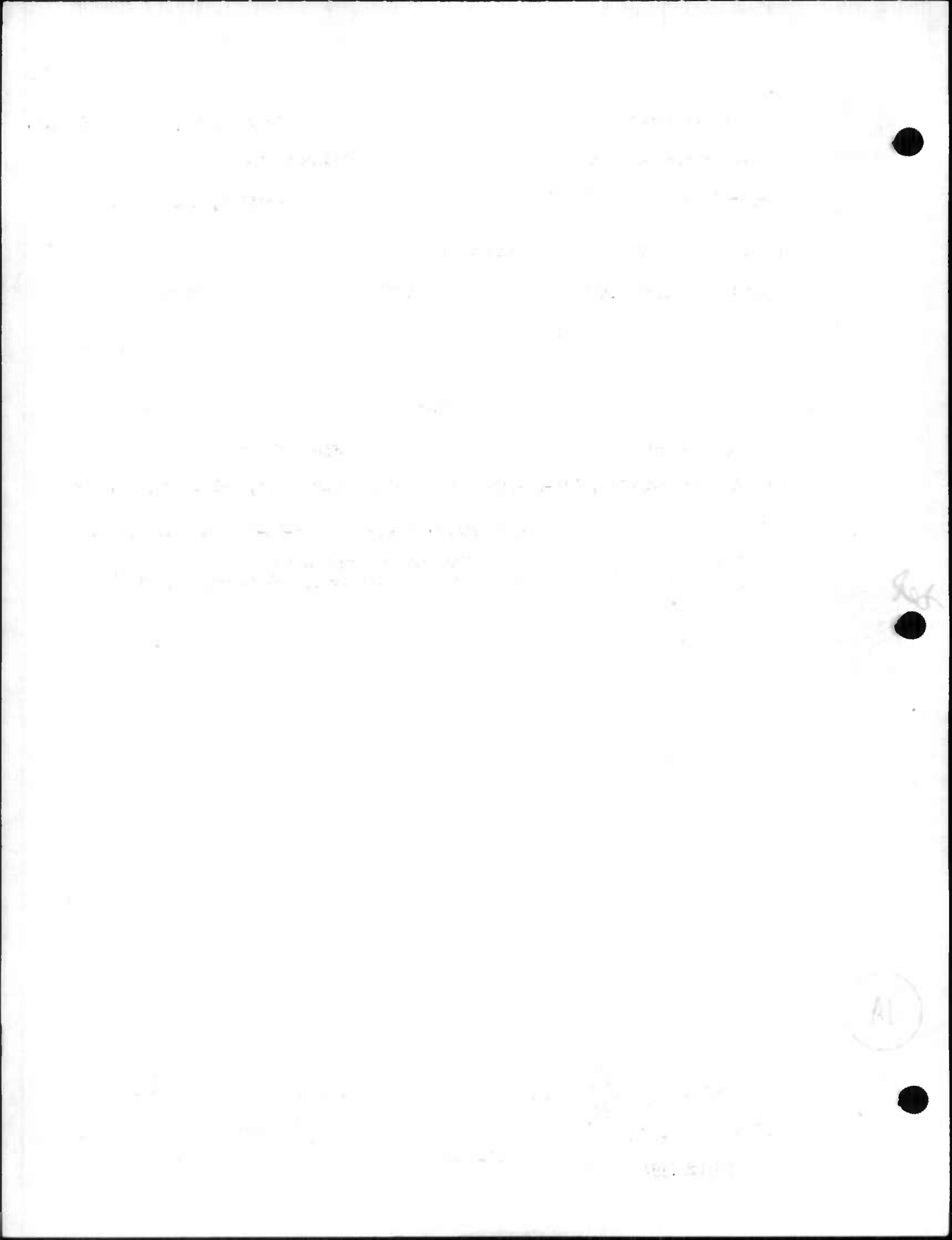
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04050

Certificate of Death

Item 10b, per F.H. G-744 2/12/97 reb

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Vera Humphrey

2. Date of Death
Month Day Year
February 10, 19973. Time of Death
10:05am

4a. Facility Name (If not institution, give street and number)

BOWIE HEALTH CENTER

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

5. Social Security Number

233-38-6305

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 14, 1925 WEST VIRGINIA

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

BOWIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

16010 EXCALIBUR ROAD APT.10D

10f. Zip Code

20716

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

1 YEAR

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

STATISTICIAN

16b. Kind of Business/Industry

SOCIAL SECURITY

17. Father's Name (First, Middle, Last)

WILLIAM HUMPHREY

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET WICKS

19a. Informant's Name/Relationship (Type, Print)

MILDRED GOFF- sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

317- 71ST AVE. SEAT PLEASANT, MD. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM. GARDENS Timonium, MARYLAND

Date
Feb 14 1997

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Calvin B. Scruggs

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON STREET BALTO, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CARDIAC ARREST.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D33942

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. DUGGAL, MD,

7253 B

HANOVER PARKWAY

GREENBELT.

MD 20770

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Davidson-Pandella

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04051

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janet Marie Hegarty

2. Date of Death

February 5

1997

3. Time of Death

7:05 pm

4a. Facility Name (If not institution, give street and number)

Deaton Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

217-40-5360

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3/28/1943

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

611 S. Charles Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

disabled

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Arthur Drager, Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Light St., Baltimore, Md. 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Memorial Gar.

Date

2/7/97

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

R. Gay with

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Ave., Catonsville, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

PNEUMONIA / ASPIRATION

Due to (or as a consequence of):

RESPIRATORY FAILURE

Due to (or as a consequence of):

FAMILIAL MYOCLONIC SEIZURES/EPILEPSY

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

~ 7 days

- 7 days

1985 +

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA / RECURRENT CLUS (ILEUS)

CINGULAL HYPERTROPHY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide datamined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

JAMES P. G. FLYNN MD / James P. G. Flynn

29c. License number

DO 1346

29d. Date signed (Month, Day, Year)

Feb 6 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES P. G. FLYNN MD DEATON SPECIALTY HOSPITAL 611 SOUTH CHARLES 21230

31. Data filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

John R. Rondon

State
Registrar

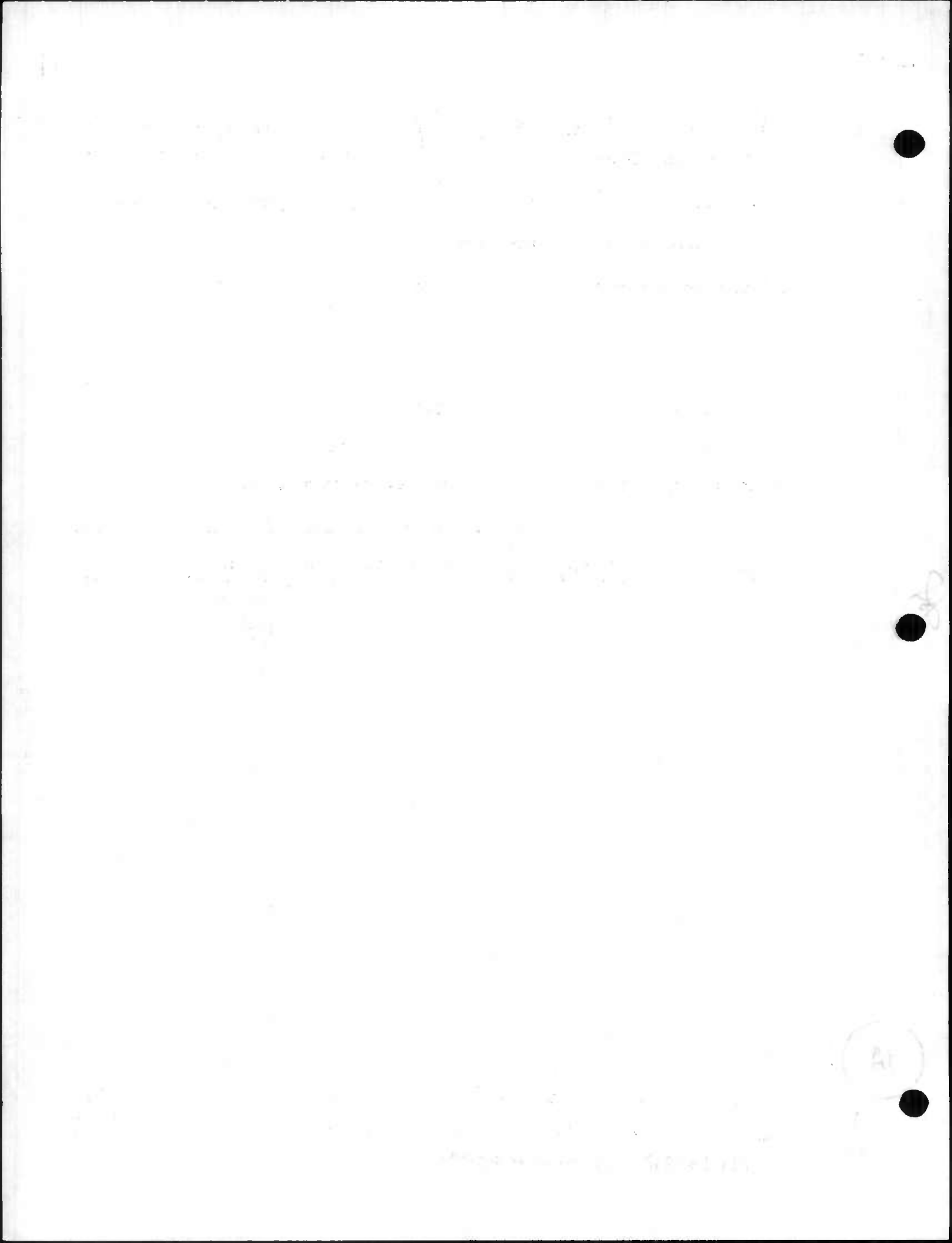
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
5056.Physician
/Medical
ExaminerTo Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04052

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Tyyne Elina Heffner

2. Date of Death

Month Day Year
FEB. 9, 1997

3. Time of Death

11:52pm

4a. Facility Name (If not institution, give street and number)

7840 Camp Road

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

217-24-6464

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 17, 1917

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

411 Audrey Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Hotel Industry

17. Father's Name (First, Middle, Last)

John Kyrola

18. Mother's Name (First, Middle, Maiden Surname)

Matilda Kuusisto

19a. Informant's Name/Relationship (Type, Print)

Michael George Heffner/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7840 Camp Road Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 2/10/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the pancreas

b. with metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0283

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. E. Subong, Jr., M.D. 206 Crain Highway, S.W. Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Gina Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04053

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCES HAMLIN				2. Date of Death Month Feb Day 10 Year 1997				3. Time of Death 4:00 P.M.	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-03-7686		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) AUG 27, 1905		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville	
To Be Completed by Funeral Director	10e. Street and Number 207 Blakeney Road				10f. Zip Code 21228		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Label Manufacturer					
	17. Father's Name (First, Middle, Last) George Ambrose				18. Mother's Name (First, Middle, Maiden Surname) Alice "Unknown"					
	19a. Informant's Name/Relationship (Type, Print) Audrey Jean Rink/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Blakeney Road Catonsville, MD 21228					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 2/11/97		20c. Location - City or Town, State Baltimore, MD					
	21. Signature of Funeral Service Licensee Dawn F. McDonald				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228					
	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier D. Bishara M.D.				29c. License number PD 9885		29d. Date signed (Month, Day, Year) Feb, 10, 1997			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haytham Bishara, St Agnes Hospital 900 Caton Ave. Baltimore MD 21229									
	31. Date filed (Month, Day, Year) FEB 12 1997									
	32. Registrar's Signature Jane Farkas-Randall									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

213

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04054

Certificate of Death



Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHNSON, BEATRICE				2. Date of Death Month February Day 11 Year 97		3. Time of Death 1:50	
	4a. Facility Name (If not Institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-26-2946		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83		8. Date of Birth (Month, Day, Year) 9-12-1913	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10e. Street and Number 2040 Ashland Avenue		10f. Zip Code 21205		10g. Citizen of What Country? USA		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th Collega (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Housekeeping			
	17. Father's Name (First, Middle, Last) Edward Bailey		18. Mother's Name (First, Middle, Maiden Surname) Della Lawson		19a. Informant's Name/Relationship (Type, Print) Della Johnson (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2040 Ashland Ave. Balto., Md. 21205	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 2-18 Landsdowne, Md.		20d. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Dennis B. Cagle		22. Name and Address of Facility Cadle Funeral Services 5502 Winner Ave. Balto., Md. 21215		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Pulmonary Embolism Due to (or as a consequence of): b. Diabetes Mellitus Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 2-11-97		28b. Time of Injury 1:50 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier EN ZAYAT, MD		29c. License number 00051443		29d. Date signed (Month, Day, Year) 2/11/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EN ZAYAT, MD		31. Date filed (Month, Day, Year) FEB 12 1997		32. Registrar Julie Burton			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04055

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Perlie JONES					2. Date of Death Month February Day 10 Year 1997		3. Time of Death 4:45 am	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center					4b. City, Town, or Location of Death Boseale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-10-4189		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 14, 1898		9. Birthplace (State or Foreign Country) VA
	Usual Residence of Decedent								
10a. State MD		10b. County Baltimore		10c. City, Town or Location Dundalk			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 116 Walnut Ave.				10f. Zip Code 21222		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Bethlehem Steel		
17. Father's Name (First, Middle, Last) Solomon Jones					18. Mother's Name (First, Middle, Maiden Surname) Betty Edwards				
19a. Informant's Name/Relationship (Type, Print) Charles Jones/son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3128 Mondawmin Ave. Balto., MD 21216				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hills		Date 2-15	20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility James A. Morton & Sons Funeral Home 1701 Laurens St. Balto., MD 21217				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <div style="display: flex; justify-content: space-between;"><div style="width: 80%;">a. Abdominal Carcinomatosis Due to (or as a consequence of):</div><div style="width: 15%;">Approximate Interval Between Onset and Death Months</div></div> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <div style="display: flex; justify-content: space-between;"><div style="width: 80%;">b. Due to (or as a consequence of):</div><div style="width: 15%;"></div></div> <div style="display: flex; justify-content: space-between;"><div style="width: 80%;">c. Due to (or as a consequence of):</div><div style="width: 15%;"></div></div> <div style="display: flex; justify-content: space-between;"><div style="width: 80%;">d. Due to (or as a consequence of):</div><div style="width: 15%;"></div></div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Dementia							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 					29c. License number 041399		29d. Date signed (Month, Day, Year) 2/10/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore Stephens M.D. 1005 North Point Blvd. #724 Baltimore, Maryland 21224									
31. Date filed (Month, Day, Year) FEB 12 1997			32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04056

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCIS

JOHNSON

2. Date of Death

FEB

Day

9

Year

1997

3. Time of Death

09:59 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH CHARLES HEALTH CARE CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

156-32-3425

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 6, 1943

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

309 W. LAFAYETTE AVENUE

10f. Zip Code

21217

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HAIR STYLIST

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

DONAVIN

JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA LENA MCGUIRE

19a. Informant's Name/Relationship (Type, Print)

THOMAS TERRELL (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1221 E. CHASE ST., BALTIMORE, MD. 21202

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

2-11-97

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

J. Brown

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.

2140 N. FULTON AVENUE, BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CARCINOMA

Due to (or as a consequence of):

b. SQUAMOUS CELL CARCINOMA OF COLON

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Prabhakar

29c. License number

D24100

29d. Date signed (Month, Day, Year)

2-11-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MADURA L. PRABHAKAR M.D. F.A.A.F.P. 21150602 EMS RD BAL MD 21220

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

K. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOTED: 11/1/58

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04057

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANTONA KELLY

2. Date of Death
Month Day Year

FEBRUARY 9 1997 6:30 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

166-28-0331

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 9, 1923

9. Birthplace (State or Foreign Country)

Puerto Rico

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Annes

10c. City, Town or Location

Centreville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

105 Gadd Dr.

10f. Zip Code

21617

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Felix Roca

18. Mother's Name (First, Middle, Maiden Surname)

Petra Fernandez

19a. Informant's Name/Relationship (Type, Print)

Robert W. Kelly

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

105 Gadd Dr., Centreville, MD 21617

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Francis Catholic Cem. 2/14/97 Henryville, IN

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.
6009 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiopulmonary Arrest.

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier
29c. License number
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert W. Anterman, MD 7141 Security Blvd, Baltimore MD 21207

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

J. Anderson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04058

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert J. Kahl

2. Date of Death

February 6, 1997

Day

Year

3. Time of Death

3 A.M.

4a. Facility Name (If not institution, give street and number)

4119 Link Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-28-7972

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 1, 1932

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4119 Link Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Freight Co.

17. Father's Name (First, Middle, Last)

Jacob Joseph Kahl

18. Mother's Name (First, Middle, Maiden Surname)

Helen Wdzieczny

19a. Informant's Name/Relationship (Type, Print)

Doris M. Kahl (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4119 Link Ave., Baltimore, MD 21236

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens 2/10/97 Bel Air, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Oral Cancer

Approximate Interval Between Onset and Death

17 Months

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24149

29d. Date signed (Month, Day, Year)

2-6-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorothy Snow, M.D., 10 N. Greene Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04059

ITEM: 1PER DR.G-744 2-13-97 eoh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) MANGOLD

MARTHA CECILIA MANGOLD KEEFER

2. Date of Death

Month Day Year
FEBRUARY 9, 1997

3. Time of Death

12:35 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MARINER NURSING HOME (SUMMIT)

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

214-12-4427

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MARCH 7, 1921

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

303 MAIDEN CHOICE LANE

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

HOSPITAL

17. Father's Name (First, Middle, Last)

JOHN ATKINSON

18. Mother's Name (First, Middle, Maiden Surname)

ELSIE GAMMIL

19a. Informant's Name/Relationship (Type, Print)

CAREY D. MANGOLD (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8762 CHARFORD DRIVE - HUNTINGTON BEACH, CALIFORNIA 92646

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY, INC

Data

20c. Location - City or Town, State

BELTSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Interstitial Fibrosis

Approximate Interval Between Onset and Death

8 years

Due to (or as a consequence of):

Rheumatoid Arthritis

8 years

Due to (or as a consequence of):

Hypertensive Heart Disease

Due to (or as a consequence of):

Hypertension, arteriosclerotic

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral aneurysm (electric puncture)

Myopathy, steroids-induced.

Diabetes mellitus, steroids-induced.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D09293

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RAFAEL MARIN

- 4355 WILKENS AVENUE - SUITE 306 -BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

S. A. WARDEN - R. D. DALL

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04060

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anthony Loiacono

2. Date of Death
Month Day Year

Feb. 10, 1997

3. Time of Death

10:45 pm

4a. Facility Name (If not institution, give street and number)

4 A Northship Rd.

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-12-4432

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Nov. 2, 1924

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4 A Northship Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

1 yr.

16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Joseph S. Loiacono

18. Mother's Name (First, Middle, Maiden Surname)

Anna Tripoli

19a. Informant's Name/Relationship (Type, Print)

Marianne Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Eastship dundalk Md. 21222

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cem.

Date

2-13

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connolly Funeral Home Of Dundalk

7110 Sollers Point Rd. 21222

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval between Onset and Death

2 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Russell, Staff Physician

29c. License number

D19714

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL RUTEN J430MC 7440 EASTERN AVE BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Medical Director: After this certificate has been signed by the attending physician and completed, it will be filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04061

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Mather				2. Date of Death Month Day Year February 7, 1997		3. Time of Death 7:03 A.M.	
	4a. Facility Name (If not institution, give street and number) Harbor Hospital Center				4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 213-10-4679	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 7, 1906		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Glen Burnie			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 412 Welham Avenue			10f. Zip Code 21061		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) cab driver		16b. Kind of Business/Industry transportation			
	17. Father's Name (First, Middle, Last) William N. Mather				18. Mother's Name (First, Middle, Maiden Surname) Areatta Terry			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charles F. Mather			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Welham Avenue Glen Burnie, MD 21061				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Memorial Park		20c. Location - City or Town, State 2/10 Sykesville, Maryland			
	21. Signature of Funeral Service Licensee <i>Paul Hagen</i>			22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <i>Chronic Obstructive Pulmonary disease</i> Due to (or as a consequence of): b. <i>Status Post-Colostomy</i> Due to (or as a consequence of): c. <i>Dehydration</i> Due to (or as a consequence of): d. <i>History of Pneumonia</i>							<i>Chronic</i> <i>8 1/2 weeks</i> <i>4 weeks</i> <i>4 to 6 weeks.</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. M. N. Sairee</i>		29c. License number		29d. Date signed (Month, Day, Year) February 7, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mirza Nusairee, M.D., 7845 Oakwood Rd., Glen Burnie, Maryland 21061								
31. Date filed (Month, Day, Year) FEB 12 1997		32. Registrar's Signature <i>June Davidson-Pond</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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• *Journal of Management Education* 32(10):1033-1044

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State of Maryland / Department of Health and Mental Hygiene **97 04062**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MABEL MADDEN McDOWELL

2. Date of Death

FEB. 7, 1997

3. Time of Death

7:20pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

604 N. Woodington Road

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

216-84-5810

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 24 1964

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

REISTERSTOWN

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

14 St. Paul Ave.

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No 3-4-83

If Yes, Give Year or Dates: 5-9-85

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CORRECTIONAL OFFICER

16b. Kind of Business/Industry

DIVISION OF CORRECTION

17. Father's Name (First, Middle, Last)

Murton P. Hammond

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Madden

19a. Informant's Name/Relationship (Type, Print)

Charlotte Taft- Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 St. Paul Ave. Reisterstown, Md. 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest Vet. Cem. 2-11-97 Owings Mills, Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Blynn B. Harris

22. Name and Address of Facility

March H. West
4300 Wabash Avenue Baltimore 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Progressive weakness and malnutrition

Due to (or as a consequence of):

b. Carcinoma of rectum -

Due to (or as a consequence of):

c. Liver metastases -

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

Hospice

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. A. Sarshar, M.D.

29c. License number

D-12872

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. A. Sarshar, MD - 3455 Wilkens Ave 21229

State
Registrar

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04063

Reg. No.

| | | | | | | | | | | | |
|--|--|--|---|---|--|---------------------------------|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ethel Mack | | | | | | 2. Date of Death
Month 02 Day 09 Year 97 | | 3. Time of Death
11:40 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Medical Center | | | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
105-16-9213 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
12-6-1913 | | 9. Birthplace (State or Foreign Country)
Md | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
942 Rosedale Street | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U. S. A. | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7th grade College (1-4or 5+) NA | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Sales Clerk | | | 16b. Kind of Business/Industry
Hutzlers | | | |
| | 17. Father's Name (First, Middle, Last)
Thomas Burke | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Burke | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
David Mack - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3220 Bluehill Road Balt, Md 21207 | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Uoshell Memorial Park | | 20c. Location - City or Town, State
2-12-97 Baltimore, Md | | | | | | |
| | 21. Signature of Funeral Service Licensee
Gabrielle Cook | | | | 22. Name and Address of Facility
March Funeral Home - West
4300 Wabash Ave Baltimore, Md 21215 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; align-items: flex-start;"> <div style="flex: 1;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="flex: 2;"> <p>a. Pneumonia
Dua to (or as a consequence of):</p> <p>b. End stage renal disease
Dua to (or as a consequence of):</p> <p>c.
Dua to (or as a consequence of):</p> <p>d.
Dua to (or as a consequence of):</p> </div> </div> | | | | | | | | | | Approximate interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cardiac arrhythmias | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
Elizabeth Stoller MD | | | | | 29c. License number
P10224 | | | 29d. Date signed (Month, Day, Year)
02-09-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Elizabeth Stoller 22 S. Greene Street Baltimore, MD 21201 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | | | | 32. Registrar's Signature
Jane Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04064

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte Baldwin Mansfield

2. Date of Death

Feb 09 1997

3. Time of Death

0209A

4a. Facility Name (If not institution, give street and number)

Koswick North Care Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

084-16-7791

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 2, 1922

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

SPARKS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1936 Akehurst Rd.

10f. Zip Code

21152

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert F. Baldwin

18. Mother's Name (First, Middle, Maiden Surname)

Blanche McCollum

19a. Informant's Name/Relationship (Type, Print)

Nicholas J. Mansfield

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1936 Akehurst Rd., Sparks, MD 21152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Mem. Gardens 1997

Date

13 FEB

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Lowell M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

e. Pneumonia

Due to (or as a consequence of):

b. Chronic Disease impaired immune system

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 days

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph W. Gellman

29c. License number

D22334

29d. Date signed (Month, Day, Year)

9 Feb 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph W. Gellman 710 W 40th Street Baltimore 21211

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

u

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04065

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel Webster Mays, Jr.

2. Date of Death

Feb. 11, 1997

3. Time of Death

12:40 AM

4a. Facility Name (If not institution, give street and number)

12410 Falls Rd.

4b. City, Town, or Location of Death

COCKEYSVILLE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

215-09-3548 A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 28, 1909

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

COCKEYSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12410 Falls Rd.

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Diesel Mechanic

16b. Kind of Business/Industry

M.T.A.

17. Father's Name (First, Middle, Last)

Daniel Webster Mays, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances Cora Merryman

19a. Informant's Name/Relationship (Type, Print)

Agnes C. Mays

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12410 Falls Rd., Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Dulaney Valley Mem. Gardens 1997

Date
14 FEB

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Victor Lengrand, Jr.

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

10 min

20 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.O.P.D.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Paul J. Edgar, M.D.

29c. License number

D 01939

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Paul Edgar, M.D., Suite 310, 515 Fairmount Ave., Towson, MD 21204

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Gina Davidson-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

9

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

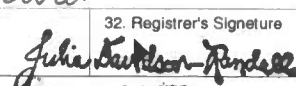
State of Maryland / Department of Health and Mental Hygiene

97 04066

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LONNIE L. MOORE JR. | | | | 2. Date of Death
Month Day Year
FEB. 09, 1997 | | 3. Time of Death
12:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
629 LAKEWOOD | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
241-20-4839 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 17, 1919 | |
| | 9. Birthplace (State or Foreign Country)
North Carolina | | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
629 LAKEWOOD AVE. | | 10f. Zip Code
21205 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Construction | | 16b. Kind of Business/Industry
Building | | 17. Father's Name (First, Middle, Last)
Lonnice L. Moore Sr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Coley | | 19a. Informant's Name/Relationship (Type, Print)
ANNIE B. MOORE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
629 LAKEWOOD AVE., BALTO, MD, 21205 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
South View | | 20c. Location - City or Town, State
2-15-97 Kinston, N.C. | | 21. Signature of Funeral Service Licensee
James A. Morton | | 22. Name and Address of Facility
James A. Morton and Sons, 1701 LAURENS ST BAL, MD, 21217 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | |
| | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
O.C.M.E. | | 29c. License number
29d. Date signed (Month, Day, Year)
FEB. 11, 1997 | |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201 | | 31. Date filed (Month, Day, Year)
3-12-1997 | | 32. Registrar's Signature
Davidson-Randall | | | |

| | | | | | |
|---|--|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN MARCUS MCCANN JR. | | 2. Date of Death
Month Day Year
FEBRUARY 10, 1997 | | 3. Time of Death
12:10 P.M. |
| | 4e. Facility Name (If not institution, give street and number)
PRINCE GEORGES GENERAL HOSPITAL | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
unk. | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
n/a Yrs. | If Under 1 Year
Months Days
3 16 | 8. Date of Birth (Month, Day, Year)
OCT. 27, 1996 |
| | 9. Birthplace (State or Foreign Country)
MD | | Usual Residence of Decedent | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Bowie | 10c. City, Town or Location
Mitchellville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
3403 Inverwood Lane | | 10f. Zip Code
20721 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) n/a College (1-4 or 5+) n/a | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
n/a | | 16b. Kind of Business/Industry
n/a | | |
| | 17. Father's Name (First, Middle, Last)
John Marcus McCann, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Vilinda Ray | | |
| | 19a. Informant's Name/Relationship (Type, Print)
John McCann/father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3403 Inverwood Lane Mitchellville, MD 20721 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill | | 20c. Location - City or Town, State
2/15 Glen Burnie, MD |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 21217 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death)
e. SUDDEN INFANT DEATH SYNDROME
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
FEBRUARY 11, 1997 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
 | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04068

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Leona Minghini

2. Date of Death

Month

Day

Year

Feb

04

1997

3. Time of Death

6:26 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Bel Air Nursing & Rehabilitation Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

217-26-2546

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 26, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

238 Wakely Terrace

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Sunpapers

17. Father's Name (First, Middle, Last)

Robert Townsley

18. Mother's Name (First, Middle, Maiden Summa)

Catherine Staubitz

19e. Informant's Name/Relationship (Type, Print)

Catherine Hooker (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

238 Wakely Terrace, Bel Air, MD. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Mem. Park

Date

2/7/97

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schmunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

7 years

c. Insulin Dependent Diabetes Mellitus

Due to (or as a consequence of):

20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D34652

29d. Date signed (Month, Day, Year)

February 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Scott Haswell 2 North Ave Bel Air Maryland 21014

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04069

| | | | | | | | | | | | | |
|---|---|--|---|---|--|---------------------------------|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Margaret Maisch | | | 2. Date of Death
Month February Day 10 Year 1997 | | | 3. Time of Death
12:00 AM | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Good Samaritan Hospital | | | 4b. City, Town, or Location of Death
Baltimore | | | 4c. County of Death
N/A | | | | | |
| Funeral
Director | 5. Social Security Number
219-30-2686 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
94 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 16, 1902 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| | 10a. State
Maryland | | | 10b. County
N/A | | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10e. Street and Number
3012 Chesterfield Avenue | | | 10f. Zip Code
21213 | | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
12th grade | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | | | | |
| | 17. Father's Name (First, Middle, Last)
George J. Noeth | | | 18. Mother's Name (First, Middle, Maiden Surname)
Caroline Krampe | | | 19a. Informant's Name/Relationship (Type, Print)
Yvonne Giguere (Daughter) | | | | | |
| Physician
/Medical
Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1506 Hunters Mill Rd., White Hall, Maryland 21161 | | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Most Holy Redeemer Cem. 2-13 | | | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Schimunek Funeral Home
3331 Brehms Lane, Baltimore, Maryland 21213 | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Uro sepsis
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
Jihad Youssouf, M.D. | | | 29c. License number
P10584 | | | 29d. Date signed (Month, Day, Year)
February 10, 1997 | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, M.D 21239 | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 12 1997 | | | 32. Registrar's Signature
 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04070

| | | | | | | | | |
|--|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
TRISTAN PAUL MERCER | | | | 2. Date of Death
Month FEB. Day 09 Year 1997 | | 3. Time of Death
6:50 PM. | |
| | 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
CITY | |
| Funeral
Director | 5. Social Security Number
219-37-7729 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
3 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 10, 1993 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Carroll | | 10c. City, Town or Location
Manchester | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
2520 Bachman Valley Rd. | | 10f. Zip Code
21102 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 Collega (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
None | | 16b. Kind of Business/Industry | | | |
| | 17. Father's Name (First, Middle, Last)
Stephen Paul Mercer | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Vickie L. Runk | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Stephen Mercer | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4026 Cedar Mills Rd., Randallstown Md. 21133 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Lutheran Cem. Feb. 13, 1997 Manchester, Md. | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Eckhardt Funeral Chapel
3296 Charmil Dr. Manchester, Md. 21102 | | | | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE TRAUMAS
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | |
| | 23b. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
2 9 97 | | 28b. Time of Injury
1340 P M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred
PEDESTRIAN STRUCK BY CAR | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
2520 BACHMAN VALLEY RD CARROLL CO | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
FEB. 10, 1997 | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARYLAND N. KOSKOWSKI 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04071

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

DORIS N. MARSHALL

2. Date of Death
Month Day Year

FEB. 10, 1997

3. Time of Death

5:58PM

4a. Facility Name (If not institution, give street and number)

1231 E. LAFAYETTE AVENUE

4b. City, Town, or Location of Death

BALTIMORE CITY N/A

4c. County of Death

5. Social Security Number

214-12-9952

6. Sex

1 ☐ M 2 ☐ F
X

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

JULY 21, 1923

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State
MARYLAND10b. County
N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

X ☐ Yes 2 ☐ No

10e. Street and Number

1231 E. LAFAYETTE AVENUE

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

GROCERY STORE

17. Father's Name (First, Middle, Last)

ROY JONES

18. Mother's Name (First, Middle, Maiden Surname)

GEORGIA SCOTT

19a. Informant's Name/Relationship (Type, Print)

DEBORAH BLACKWELL-DAUGHTER 2642 E. HOFFMAN STREET BALTO, MD. 21213

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CROWNSVILLE VETERANS CEM.

Date
FEB. 14, 1997

20c. Location - City or Town, State

CROWNSVILLE, MD.

21. Signature of Funeral Service Licensed

Calvin B. Scruggs, Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO, MD. 21213

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Breast

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anil UBEROI MD

29c. License number

D26748

29d. Date signed (Month, Day, Year)

2-11-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANIL UBEROI MD 4419 FALLS RD BALTO MD 21211

State
Registrar31. Date filed (Month, Day, Year)
FEB 12 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04072

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Preston Franklin Metcalf

2. Date of Death

Month
FebDay
11Year
1997

3. Time of Death

0225

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-09-4135

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 22, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

712 Dorchester Road

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Transit Bus System

17. Father's Name (First, Middle, Last)

Benjamin Franklin Metcalf

18. Mother's Name (First, Middle, Maiden Surname)

Julia Preston Renna

19a. Informant's Name/Relationship (Type, Print)

Virginia Mae Metcalf/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

712 Dorchester Rd., Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

2/13/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

MacNabb Funeral Home, P.A.

301 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Adult Respiratory Distress Syndrome

12 days

Due to (or as a consequence of):

b. Bilateral pneumonia

15 days

Due to (or as a consequence of):

c. Congestive HEART failure

2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dawn F. McDonald MD

29c. License number

PO. 9886

29d. Date signed (Month, Day, Year)

Feb 11-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Violetta Rus; St Agnes Hospital; 900 Caton Ave 21229

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04073

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARK CHARLES MORRIS

2. Date of Death

FEB

Day

1

Year

97

3. Time of Death

~ 4 AM.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

5706 Yellowrose Court

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

214-86-6979

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

30 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 9, 1966

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

5706 Yellowrose Court

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

College

17. Father's Name (First, Middle, Last)

Carl W. Morris

18. Mother's Name (First, Middle, Maiden Surname)

Roberta Spencer

19a. Informant's Name/Relationship (Type, Print)

Roberta Morris (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5706 Yellowrose Court Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. ZION CEMETERY

Date

February 6, 1997

20c. Location - City or Town, State

Lansdowne MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, Maryland 21045

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEIZURE DISORDER

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D31473

29d. Date signed (Month, Day, Year)

Feb 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICK A. TATE, MD 4565 Hemlock Cove Way Edinburg City MD 21042

State
Registrar

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

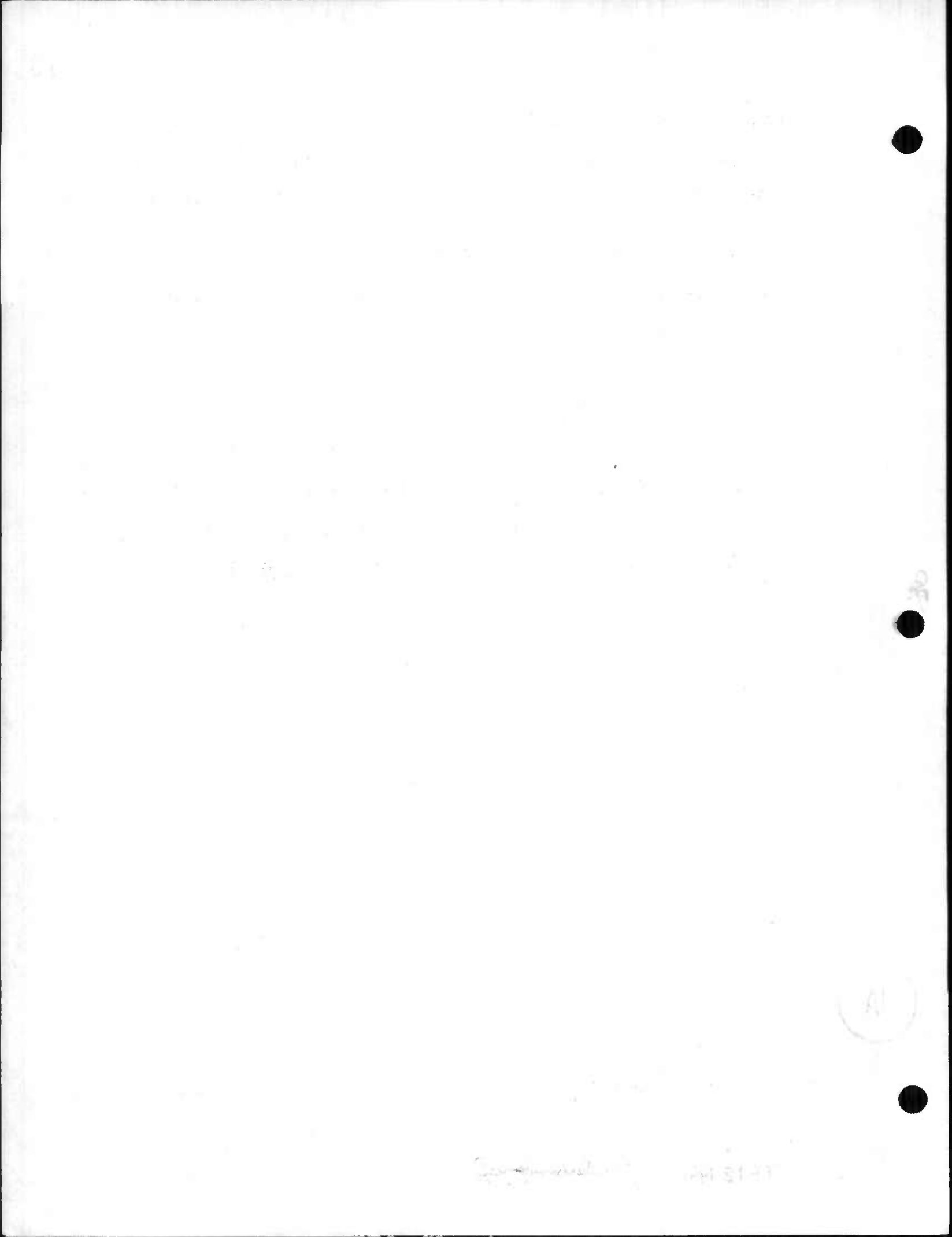
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours of death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04074

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
MARGARET NORLE | | 2. Date of Death
Month 02 Day 07 Year 97 | | 3. Time of Death
6 50pm | |
| 4a. Facility Name (If not institution, give street and number)
LEWISDALE HEBREW G C & HOSPITAL | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| 5. Social Security Number
216-01-1129 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
May 18, 1908 | | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| 10e. Street and Number
331 South Bentalou | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
United States | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
homemaker | |
| 16b. Kind of Business/Industry
own home | | 17. Father's Name (First, Middle, Last)
Charles Beitz | | 18. Mother's Name (First, Middle, Maiden Surname)
Barbara Schneider | |
| 19a. Informant's Name/Relationship (Type, Print)
Linda Cavey, daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3720 Baltimore Street Baltimore, MD 21227 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cemetery | | 20c. Location - City or Town, State
2/11/97 Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Road 21227 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Decubitus Ulcers
Due to (or as a consequence of):
c. Vascular Dementia
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
10 days
1 month
unknown | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pneumothorax | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Robert B Shochet MD | | 29c. License number
D36356 | |
| 29d. Date signed (Month, Day, Year)
February 8, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert B Shochet MD 2435 W Belvedere Ave Suite 22 Baltimore MD 21215 | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04075

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Edwin OWENS

2. Date of Death
Month Day Year

February 7 1997

3. Time of Death
2:15 PM

4a. Facility Name (If not institution, give street and number)

Charlestown CARE CENTER

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-07-3430

6. Sex

12 M 2 F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08 Month Day Year 1906

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

719 Maiden Choice Lane

10f. Zip Code

402

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Special Agent

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John Evan Owens

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Griffiths

19a. Informant's Name/Relationship (Type, Print)

Beatrice Owens/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

719 Maiden Choice Lane Brookside 402 Catonsville, Md. 21228

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory 2-8-97

20c. Location - City or Town, State

Beltsville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton Funeral Home, Inc.

2134 Willow Spring Rd. Balto., Md. 21222

23a. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Prostate CANCER

Approximate Interval Between Onset and Death

Twenty Years

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

28. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47781

29d. Date signed (Month, Day, Year)

February 7, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State
Registrar

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-9.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04076

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edythe

Ogburn

2. Date of Death

Month Day Year
FEBRUARY 9, 1997

3. Time of Death

5:52 P.M.

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

225-66-2679

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCTOBER 2 1949

9. Birthplace (State or Foreign Country)

TENNESSEE

Usual Residence of Decedent

10a. State

VIRGINIA

10b. County

ARLINGTON

10c. City, Town or Location

ARLINGTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2414 WALTER REED DRIVE

10f. Zip Code

22206

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES/OFFICE MANAGER

16b. Kind of Business/Industry

MARKETING FIRM

17. Father's Name (First, Middle, Last)

BAXTER HUEY STEPHENSON

18. Mother's Name (First, Middle, Maiden Surname)

CLARA BEAUCHAMP

19a. Informant's Name/Relationship (Type, Print)

MARVIN L. OGBURN / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2414 WALTER REED DRIVE ARLINGTON, VIRGINIA 22206

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NATIONAL MEMORIAL PARK

Date

FEB. 13 1997

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

Spine & Phillips

22. Name and Address of Facility

LOUDON PARK FUNERAL HOME

3620 WILKENS AVENUE BALTIMORE, MARYLAND 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

b.

Liver failure

Due to (or as a consequence of):

30 days

c.

Autoimmune hepatitis

Due to (or as a consequence of):

60 days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, Uremia, Encephalopathy

Coagulopathy, Hypothyroidism, pulmonary edema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Amy Lawrence, MD RESIDENT PHYSICIAN

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMY R. LAWRENCE, MD, TOWER 110, JHH, BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04077

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS

PEDERSEN

2. Date of Death
Month Day Year
FEBRUARY 10, 19973. Time of Death
7:00 AMFuneral
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

219-12-8490

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 16, 1925

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

108 74th St.

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Purchasing Manager

16b. Kind of Business/Industry

Westinghouse

17. Father's Name (First, Middle, Last)

Thomas

Pedersen, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Caroline

Neilson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Kaern P. Wright/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 Church Rd. Owings Mills, Md. 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gdns. 2/13/97

Date

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

2 DAYS

b. PNEUMONIA

Due to (or as a consequence of):

2 DAYS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

02-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



AL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04078

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDITH V. POTOCHNEY | | | | 2. Date of Death
Month Day Year
February 11, 1997 | | 3. Time of Death
3:20 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
214 22 6231 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 6, 1910 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | Usual Residence of Decedent
10a. State
Maryland | | | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | |
| | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
5310 Selfridge Ave. | | 10f. Zip Code
21205 | |
| To Be Completed by Physician/Medical Examiner | 10g. Citizen of What Country?
United States | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 Collage (1-4 or 5+) | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Domestic | | | |
| | 17. Father's Name (First, Middle, Last)
Victor Sudvoy | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Julia (Unknown) | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Lynn A. Crispens / granddaughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5310 Selfridge Ave., Baltimore, MD 21205 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. 2/12/97 | | | |
| To Be Completed by Physician/Medical Examiner | 20c. Location - City or Town, State
Rosedale, MD | | | | 21. Signature of Funeral Service Licensee
Stephen D. Lohrmann | | | |
| | 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286 | | | | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. PANCYTOPENIA
Due to (or as a consequence of):
b. MYELODYSPLASIA OF BONE MARROW
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Kendall R. Faulkner | | | |
| | 29c. License number
D25643 | | | | 29d. Date signed (Month, Day, Year)
2/12/97 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204 | | | | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | |
| | 32. Registrar's Signature
Jane Davidson-Kendall | | | | 33. Registrar's Title
Registrar | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04079

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN POWELL

2. Date of Death

February 10, 1997

3. Time of Death

4:35 AM

4a. Facility Name (If not institution, give street and number)

Liberty Medical Center, 2600 Liberty Height

BALTIMORE, MD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

MD

Funeral
Director

5. Social Security Number

213-60-2172

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
8-10-52

9. Birthplace (State or Foreign Country)

BALTO. MD

Usual Residence of Decedent

10a. State

MD

10b. County

MD

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6510 FALKIRK ROAD

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 TH GRADECollege (1-4 or 5+)
1 YR

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OFFICE ASSISTANT

16b. Kind of Business/Industry

STATE POLICE

17. Father's Name (First, Middle, Last)

GEORGE RAY

18. Mother's Name (First, Middle, Maiden Surname)

CORREN ISSAC

19a. Informant's Name/Relationship (Type, Print)

ANGELA C. POWELL / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6510 FALKIRK ROAD, BALTIMORE, MD 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS CEMETERY

Date

2/14/97

20c. Location - City or Town, State

ARBUTUS, MD

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICES
5151 BALTO. NAT'L PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE of AIDS

Due to (or as a consequence of):

b. AIDS enteropathy

Due to (or as a consequence of):

c. Electrolytes Imbalance

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kwang N. Kim MD

29c. License number

D 17031

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KWANG N. KIM, MD, 2600 Liberty Height, BALTIMORE, MD. 21215.

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Film 10e,19b per FH Film G745 3-7-97 rja

Certificate of Death

Reg. No.

97 04080

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL C.

Podolsky

2. Date of Death

Month

Day

Year

February

7

1997

3. Time of Death

6:23 pm

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

193-10-8885

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 4, 1916

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Clinton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4401 Henderson Rd.

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

4 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Construction Co.

17. Father's Name (First, Middle, Last)

Joseph Podolsky

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Stavek

19a. Informant's Name/Relationship (Type, Print)

Patricia Davis

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4401 Henderson Rd. Clinton Md. 20748

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens Of Faith

Date

2-10

20c. Location - City or Town, State

Rossville

21. Signature of Funeral Service Licensee

John E. Tuller

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk

7110 Sollers Point Rd. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Uro Sepsis

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

3 days

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Sidarous

29c. License number

D 45365

29d. Date signed (Month, Day, Year)

2-10-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael Sidarous M.D. 11701 Livingston Rd., #101 Ft. Wash., MD 20744

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

John Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97 04081

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
DAISY PATTERSON | | | | 2. DATE OF DEATH
MONTH 2 DAY 10 YEAR 97 | | 3. TIME OF DEATH
1535 P.M. | |
| 4. SOCIAL SECURITY NUMBER
214-64-0407 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
89 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
NOV. 15, 1907 | |
| 8. BIRTHPLACE (State or Foreign Country)
NORTH CAROLINA | | | | 9a. FACILITY NAME (If not institution, give street and number)
DEATON NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE | |
| 9c. COUNTY OF DEATH
N/A | | | | 10a. STATE
MARYLAND | | | |
| 10b. COUNTY
N/A | | | | 10c. CITY, TOWN OR LOCATION
BALTIMORE CITY | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
921 N. GILMOR STREET | | | |
| 10f. ZIP CODE
21217 | | | | 10g. CITIZEN OF WHAT COUNTRY?
USA. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE - American Indian, Black, White, etc.
Specify:
BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
7th GRADE | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
OWN HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last)
WILLIAM LANGSTON | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ELIZABETH (MN-UNKNOWN) | | | |
| 19a. INFORMANT'S NAME (Type/Print)
MARIE MIDDLETON | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
921 N. GILMOR ST., BALTIMORE, MD. 21217 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MT. ZION CEMETERY | | 20c. LOCATION - City or Town, State
2-14-97 BALTIMORE, MD. | | 22. NAME AND ADDRESS OF FACILITY
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE., BALTO. MD. 21217 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE., BALTO. MD. 21217 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal Failure | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| b. Congestive Heart Failure | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. Atherosclerotic Cardiovascular Disease | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
MD | | | | 29c. LICENSE NUMBER
038675 | | 29d. DATE SIGNED (Month, Day, Year)
2/11/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 12 1997 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04082

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Pawlik

2. Date of Death

February 8 1997

3. Time of Death

12:00 PM

4a. Facility Name (If not institution, give street and number)

Heritage Center Genesis Eldercare

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

213-03-4037

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 17, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7232 German Hill Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Drug Store

17. Father's Name (First, Middle, Last)

Andrew Unknown Stickel

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Unknown Unknown

19a. Informant's Name/Relationship (Type, Print)

William Victor Vogler/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

62 Katie Lane, Dover, New Hampshire 03820

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest VA Cemetery

Date

2/12/97

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

Juanita R Thomas

22. Name and Address of Facility

John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 2120623a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CORONARY ARTERY DISEASE 8 YEARS

Due to (or as a consequence of):

ESSENTIAL HYPERTENSION 10 YEARS

Due to (or as a consequence of):

CIRRHOSIS OF LIVER 5 YEARS

Due to (or as a consequence of):

PERIPHERAL VASCULAR DISEASE 7 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ OOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Harjitsingh M.D.

29c. License number

D14160

29d. Date signed (Month, Day, Year)

FEBRUARY 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARJITSINGH M.D. 5410-A RITCHIE HIGHWAY, BALTIMORE
MARYLAND-21225

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

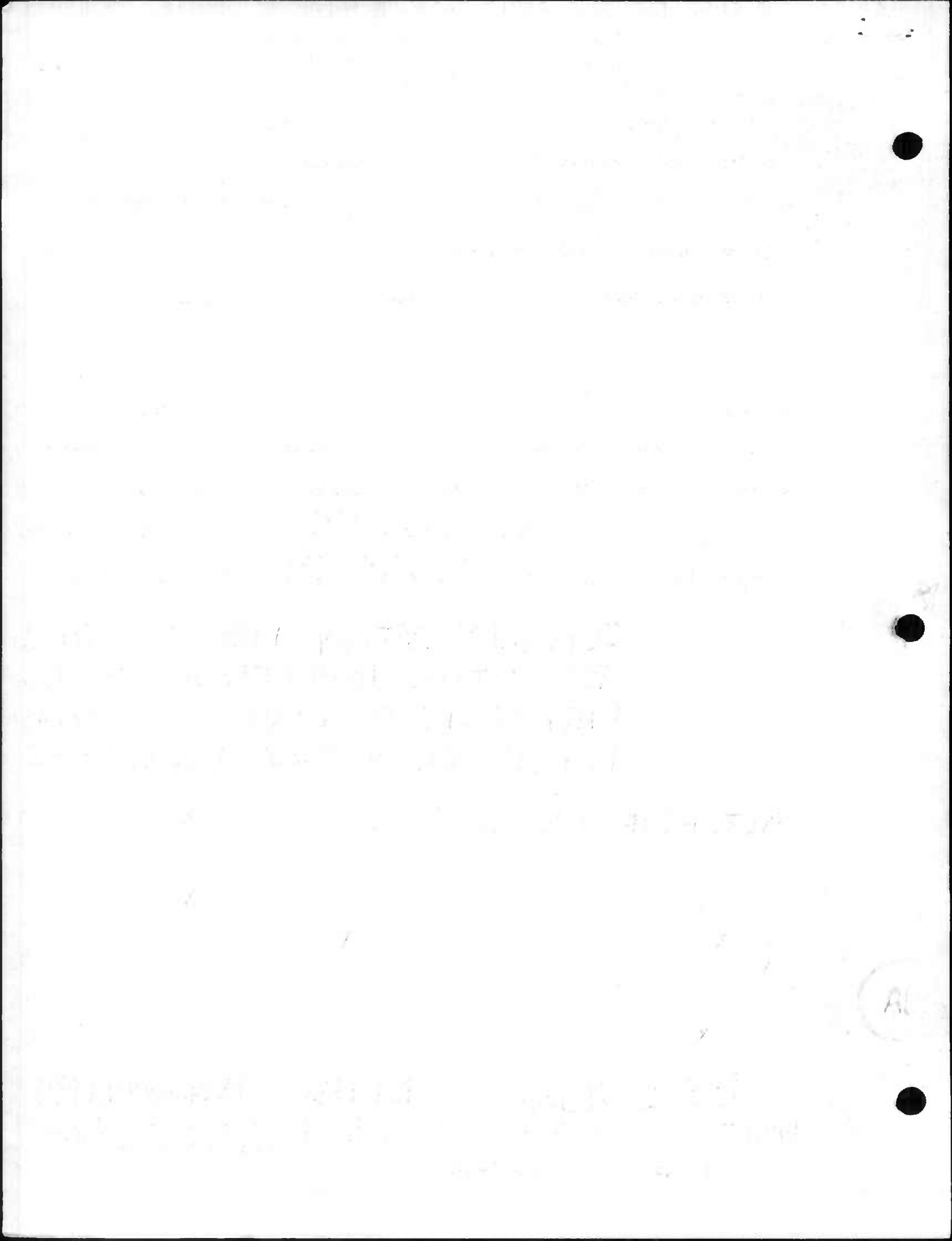
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filed in by the medical director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 1, per M.D G-744 2/12/97 reb

Certificate of Death

Reg. No.

97 04083

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ANNA RICCOBONO

2. Date of Death
Month Day Year

February 10, 1997

3. Time of Death

12:15 AM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

059-14-8218

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 13, 1921

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

502 S. Tollgate Road

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (14 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

18b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Salvatore Curreri

18. Mother's Name (First, Middle, Maiden Surname)

Angelina Todaro

19a. Informant's Name/Relationship (Type, Print)

Carmel V. Curreri (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

502 S. Tollgate Rd., Bel Air, MD 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

2/13/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schmunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Lung Cancer

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

078339

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA FRIEDMAN 101 E Wheel Road Bel Air MD 21015

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

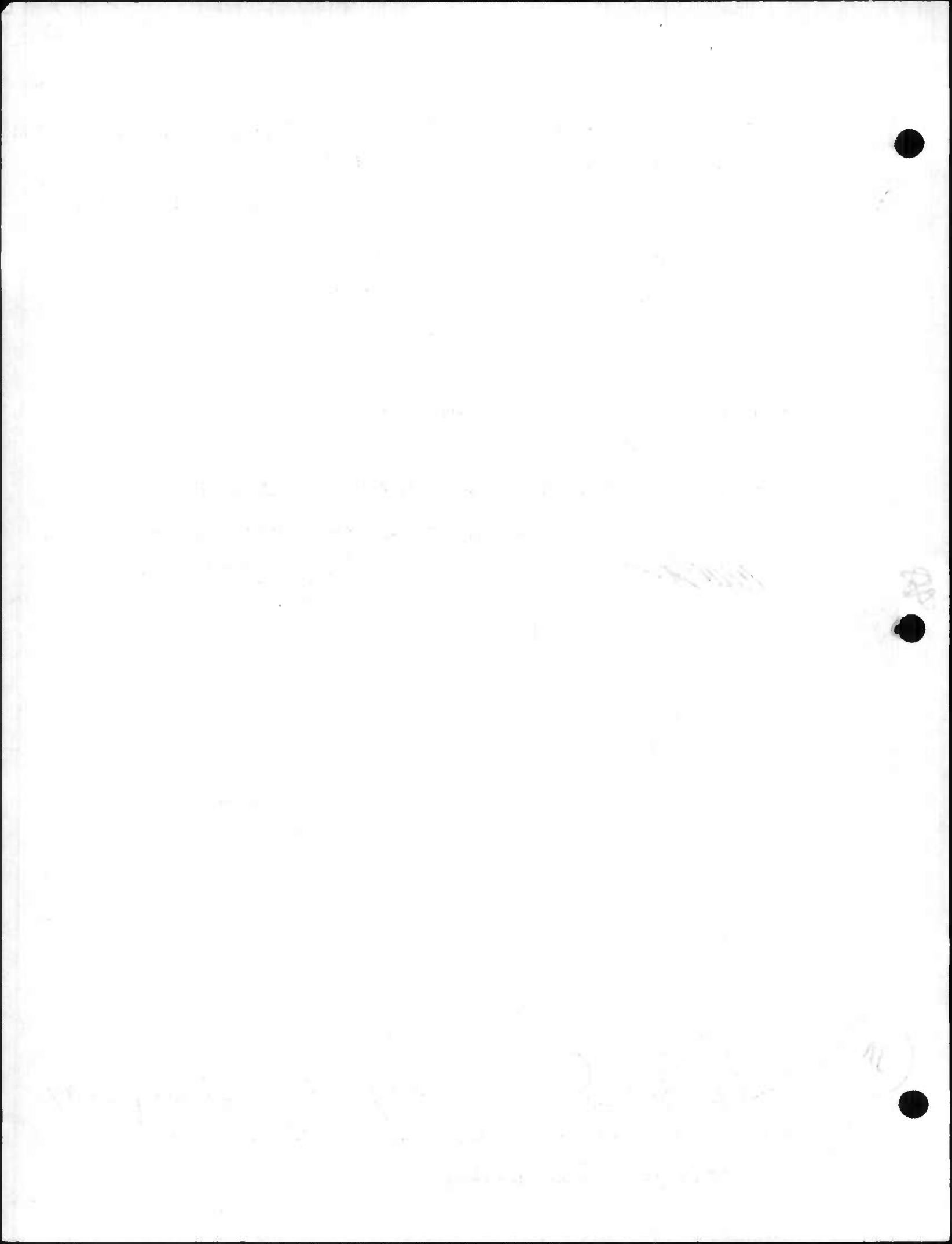
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To Registrar or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04084

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
VIOLA E. REED | | 2. Date of Death
Month 2 Day 4 Year 1997 | | 3. Time of Death
8:30 A.M. | |
| 4a. Facility Name (If not institution, give street and number)
4201 Duvall Avenue | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA |
| 5. Social Security Number
218-22-6552 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
August 19, 1910 |
| 9. Birthplace (State or Foreign Country)
Va | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | 10b. County
NA | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number
4201 Duvall Avenue | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U. S. A |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic | | 16b. Kind of Business/Industry
Home | |
| 17. Father's Name (First, Middle, Last)
Richard Epps | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sharon Palmer - Granddaughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4201 Duvall Avenue Baltimore, MD 21216 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Nat Mem Park | | 20c. Location - City or Town, State
2-7-97 Laurel, MD | |
| 21. Signature of Funeral Service Licensee
Jerome A. Thompson | | | 22. Name and Address of Facility
March F. H. West 4300 Wabash Avenue Balt, MD 21215 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Multiple CVA | | | | | |
| 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury et Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and Title of Certifier
Heal | | 29c. License number
024100 | | 29d. Date signed (Month, Day, Year)
2-11-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NADURA L. PRABHAKAR M.D 2115 OLD ARMS ROAD, BAL, MD-21220 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
Juli Davidson-Randall | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completed by the Funeral Director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04085

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NAOMI FRANCES RUSSELL

2. Date of Death

Month Day Year
FEBRUARY 08 1997

3. Time of Death

09:18 AM

4a. Facility Name (If not institution, give street and number)

4701 Aldgate Green

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

217-18-9284

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 9, 1912

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4701 Aldgate Green

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

Collage (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Ironworker

16b. Kind of Business/Industry

Shipyard

17. Father's Name (First, Middle, Last)

William Landis

18. Mother's Name (First, Middle, Maiden Summa)

Tiny (unknown)

19a. Informant's Name/Relationship (Type, Print)

Marilyn Anita Jovenal

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4701 Aldgate Green, Baltimore, Maryland 21227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Crematory

Data

Feb. 11
1997

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Loudon Park Funeral Home
3620 Wilkens Ave., Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23 ☐24 ☐25 ☐26 ☐27 ☐28 ☐29 ☐30 ☐31 ☐32 ☐33 ☐34 ☐35 ☐36 ☐37 ☐38 ☐39 ☐40 ☐41 ☐42 ☐43 ☐44 ☐45 ☐46 ☐47 ☐48 ☐49 ☐50 ☐51 ☐52 ☐53 ☐54 ☐55 ☐56 ☐57 ☐58 ☐59 ☐60 ☐61 ☐62 ☐63 ☐64 ☐65 ☐66 ☐67 ☐68 ☐69 ☐70 ☐71 ☐72 ☐73 ☐74 ☐75 ☐76 ☐77 ☐78 ☐79 ☐80 ☐81 ☐82 ☐83 ☐84 ☐85 ☐86 ☐87 ☐88 ☐89 ☐90 ☐91 ☐92 ☐93 ☐94 ☐95 ☐96 ☐97 ☐98 ☐99 ☐100 ☐101 ☐102 ☐103 ☐104 ☐105 ☐106 ☐107 ☐108 ☐109 ☐110 ☐111 ☐112 ☐113 ☐114 ☐115 ☐116 ☐117 ☐118 ☐119 ☐120 ☐121 ☐122 ☐123 ☐124 ☐125 ☐126 ☐127 ☐128 ☐129 ☐130 ☐131 ☐132 ☐133 ☐134 ☐135 ☐136 ☐137 ☐138 ☐139 ☐140 ☐141 ☐142 ☐143 ☐144 ☐145 ☐146 ☐147 ☐148 ☐149 ☐150 ☐151 ☐152 ☐153 ☐154 ☐155 ☐156 ☐157 ☐158 ☐159 ☐160 ☐161 ☐162 ☐163 ☐164 ☐165 ☐166 ☐167 ☐168 ☐169 ☐170 ☐171 ☐172 ☐173 ☐174 ☐175 ☐176 ☐

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04086

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA

REILLY

2. Date of Death

Month

Day

Year

3. Time of Death

0024

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-34-0886

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

APR 16, 1937

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

55 Wade Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Michael J. Reilly

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bordeauxreau

19a. Informant's Name/Relationship (Type, Print)

Kathleen Burch/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4444 East Benson Hwy. #298 Tucson, AZ 85706

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 2/10/97

Date

Baltimore, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

SEPTIC SHOCK

5 days

b. Due to (or as a consequence of):

ASPIRATION PNEUMONIA

5 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony R. DOTI

29c. License number

PO9886

29d. Date signed (Month, Day, Year)

Feb 6 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony R. DOTI 900 CATON AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04087

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOSEPH F. REINA | | | | 2. Date of Death
Month <u>February</u> Day <u>8</u> Year <u>1997</u> | | 3. Time of Death
<u>7A</u> | | |
| | 4a. Facility Name (If not Institution, give street and number)
STELLA MARIS HOSPICE | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
214-22-0115 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT 14, 1903 | | |
| | 9. Birthplace (State or Foreign Country)
ITALY | | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1104 LINDEN AVENUE | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6TH GRADE | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BARBER | | 16b. Kind of Business/Industry
SELF-EMPLOYED | | | |
| 17. Father's Name (First, Middle, Last)
VITO REINA | | | | 18. Mother's Name (First, Middle, Maiden Surname)
FORTUNATA SCIONTI | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
JOSEPH V. REINA (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
889 FOREST LANE - HANOVER, MD. 21076 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEW CATHEDRAL CEMETERY | | Data
2/11/97 | | 20c. Location - City or Town, State
BALTIMORE | | | |
| 21. Signature of Funeral Service Licensee
<i>Jackie D. Shannon</i> | | | | 22. Name and Address of Facility
HUBBARD FUNERAL HOME INC.
4107 WILKENS AVENUE-BALTIMORE, MD 21229 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
LUNG CANCER Metastatic | | Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
6 mos. | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Due to (or as a consequence of): | | | | | | | |
| | | Due to (or as a consequence of): | | | | | | | |
| | | Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 28. Place of Death (Check only one)
Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Kendall Faulkner</i> | | 29c. License number
D25643 | | 29d. Date signed (Month, Day, Year)
2/8/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K Faulkner MD/2300 Dulany Valley Rd/Balto MD 21204 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
<i>Jane Davidson-Randall</i> | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA

97 04088

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Earl C Riddle | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb. 10 1997 | | 3. TIME OF DEATH
12:35 P. M. | |
| 4. SOCIAL SECURITY NUMBER
246-14-1337 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
75 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
April 3, 1921 | |
| 8. BIRTHPLACE (State or Foreign Country)
North Carolina | | | | 9a. FACILITY NAME (If not institution, give street and number)
The New Childrens Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH
Baltimore City | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
Baltimore City | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
1241 West Cross Street | | | |
| 10f. ZIP CODE
21230 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Maintenance Man | | 16b. KIND OF BUSINESS/INDUSTRY
Apartment Buildings | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Grant Riddle | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Ray | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Ms. Dorothy Decker/Daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
124 Talbot Rd. P.O. BOX 818 Stevensville, MD 21666 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
Glen Haven Memorial Park | | 20c. LOCATION — City or Town, State
Glen Burnie, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Paul L. Ebaugh | | | | 22. NAME AND ADDRESS OF FACILITY
Kirkley-Ruddick Funeral Home
421 Crain Hwy. S.E. Glen Burnie, MD 21061 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death
Unknown |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Bladder Cancer | | | | | | | |
| a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| 24. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 27b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 29a. DATE OF INJURY (Month, Day, Year) | | 29b. TIME OF INJURY
M | | 29c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 29d. DESCRIBE HOW INJURY OCCURRED | | 29e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 29f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Dr. Sam Sencil | | | | 29c. LICENSE NUMBER
H0050642 | | 29d. DATE SIGNED (Month, Day, Year)
Feb. 11, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Sam Sencil 3825 Greenspring Ave. Baltimore, MD 21211 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 12 1997 | | 32. REGISTRAR'S SIGNATURE
Gina Davidson-Randall | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04089

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marian Bertha Shore

2. Date of Death

February 10, 1997

3. Time of Death

2:10 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

207-03-0128

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 27, 1908

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2126 Oak Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

8 Years

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Kline

18. Mother's Name (First, Middle, Maiden Surname)

Hallie Grassmyer

19a. Informant's Name/Relationship (Type, Print)

Cora D. Wild/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2126 Oak Road Edgemere, Maryland 21219

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 2/13/1997

Date

20c. Location - City or Town, State

Rossville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CARCINOMA RECTUM with METASTASIS.

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16188

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WALTER IMPAGLIABELLI, 121 S. EATON ST. BALTIMORE, MD 21224

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Rendell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

AL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04090

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Paul H. Shaw Jr.

2. Date of Death

February 8, 1997

3. Time of Death

9:45pm

4a. Facility Name (If not institution, give street and number)

5542 Dolores Avenue

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

250-88-0474

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 28, 1956

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5542 Dolores Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Manufacture

17. Father's Name (First, Middle, Last)

Paul H. Shaw Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Emma C. Cochran

19a. Informant's Name/Relationship (Type, Print)

Karen Shaw, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5542 Dolores Avenue Arbutus, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery 2/12

Date

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc. Arbutus
1328 Sulphur Spring Road 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic Failure

Due to (or as a consequence of):

b. Liver Metastases

Due to (or as a consequence of):

c. Malignant Melanoma

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 wks

4 mo

3 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

St Agnes Healthcare
Wm C WATERFIELD MD 900 Cato Ave Balt Md 21229

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

James Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

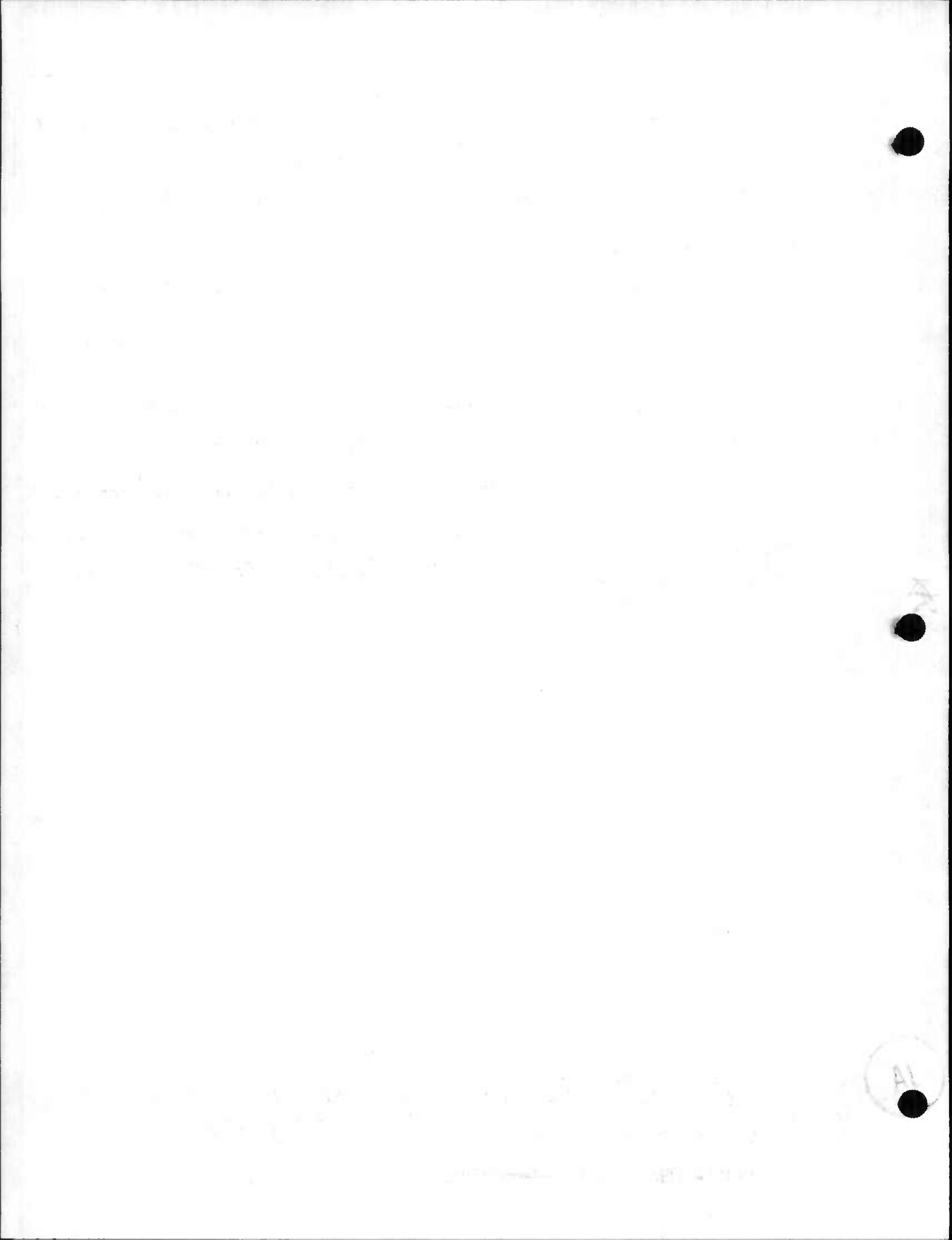
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04091

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence

Saunders

2. Date of Death
Month Day Year

02 10 97

3. Time of Death
5:52pm

4a. Facility Name (If not institution, give street and number)

1516 Retreat Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral
Director

5. Social Security Number

223-20-8859

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

8. Date of Birth
(Month, Day, Year)

03-20-20

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State
MD10b. County
NA10c. City, Town or Location
Baltimore10d. Inside City Limits
☒ Yes 2 ☐ No

10e. Street and Number

1516 Retreat Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
3rd. GradeCollege (1-4 or 5+)
NA16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Corporation

17. Father's Name (First, Middle, Last)

Sam Saunders

18. Mother's Name (First, Middle, Maiden Surname)

Blanche A. Jones

19a. Informant's Name/Relationship (Type, Print)

Lue F. Saunders

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

905 Pennsylvania Avenue Apt. 1A Balto., Md

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest VA Cem. 02-14-97 Owings Mills

Date

20c. Location - City or Town, State Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Baltimore, Maryland 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Coronary Artery Disease
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

10209

29d. Date signed (Month, Day, Year)

2-11-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANAKI KURUPU, MD BALTIMORE VA MED CTR

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To be Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04092

| | | | | | | | | | | | |
|--|--|-----------------------------|--|---|---|--|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SAMUEL LEE STEWART | | | | | 2. Date of Death
Month FEBRUARY Day 10 Year 1997 | | 3. Time of Death
12:25 AM | | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | | | |
| Funeral
Director | 5. Social Security Number
217-03-3240 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
8-1-1910 | | 9. Birthplace (State or Foreign Country)
MD | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD | | 10b. County
Balto | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
6800 Liberty Road | | | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
U. S. A | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 4yrs | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | | 16b. Kind of Business/Industry
Baltimore City Department Education | | | | |
| 17. Father's Name (First, Middle, Last)
Samuel Lee Stewart, Sr | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Florence Hill | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Cynthia Stewart-Jackson - Daughter | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2215 N. Rosedale Street Balto, MD 21216 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Mem Park | | | 20c. Location - City or Town, State
2-15-97 Arbutus, MD | | | | | |
| 21. Signature of Funeral Service Licensee
Portia Chron | | | | | 22. Name and Address of Facility
March F.H. West 4300 Wabash Avenue Balto, MD 21215 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | |
| 29b. Signature and title of certifier
Michael Rothkin, MD | | | | | 29c. License number
D43461 MD | | 29d. Date signed (Month, Day, Year)
FEBRUARY 10, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MICHAEL ROTHKIN 5401 OLD COURT ROAD RANDALLSTOWN, MARYLAND 21133 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | | | | 32. Registrar's Signature
Julia Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04093

Items: 7,8 per F.H. G-744 2/14/97 reb

Certificate of Death

Reg. No.

| | | | | | |
|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eleanor M Sweeney | | 2. Date of Death
Month Feb Day 6 Year 1997 | | 3. Time of Death
8:20 AM |
| | 4a. Facility Name (If not Institution, give street and number)
Bel Air Nursing & Rehabilitation Center | | 4b. City, Town, or Location of Death
Bel Air | | 4c. County of Death
Harford |
| Funeral
Director | 5. Social Security Number
021-03-3368 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Aug. 9, 1915 | | 9. Birthplace (State or Foreign Country)
Massachusetts | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
Baltimore |
| | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
4103 Loch Lomond Drive | | 10f. Zip Code
21236 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
12th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home |
| | 17. Father's Name (First, Middle, Last)
Edwin I. Townes | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Wilkenson | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Edward F. Sweeney (husband) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4103 Loch Lomond Drive, Baltimore, MD 21236 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Schimunek Funeral Homes, Inc.
9705 Belair Road, Baltimore, MD 21236 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. urosepsis
Due to (or as a consequence of):
c. Chronic Brain Syndrome
Due to (or as a consequence of):
d. Pseudomonas colitis | | | | | 2 weeks
2 weeks
710 years
years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pemphigoid | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D16389 | 29d. Date signed (Month, Day, Year)
Feb 6 1997 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
PERFECTO C. VALARAO, M.D. 1716 HARFORD Rd Rm 106 FALLSTON MD 21047 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

This Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04094

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|-------------------------------|--|--|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Quentin Leon Seitz Jr.</i> | | | | 2. Date of Death
Month <i>February</i> Day <i>7</i> Year <i>1997</i> | | 3. Time of Death
<i>7:30 p.m.</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>1703 Samantha Drive</i> | | | | 4b. City, Town, or Location of Death
<i>Forest Hill</i> | | 4c. County of Death
<i>Harford</i> | |
| Funeral
Director | 5. Social Security Number
<i>207-30-7047</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>59</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Oct. 28, 1937</i> | 9. Birthplace (State or Foreign Country)
<i>Pennsylvania</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | 10b. County
<i>Harford</i> | 10c. City, Town or Location
<i>Forest Hill</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
<i>1703 Samantha Drive</i> | | | 10f. Zip Code
<i>21050</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>1964-76</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>5</i> College (1-4 or 5+)
<i>years</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Executive Assistant</i> | | 16b. Kind of Business/Industry
<i>Army</i> | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
<i>Quentin L. Seitz Sr.</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Elizabeth F. Baker</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Diane F. Seitz (Wife)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1703 Samantha Drive, Forest Hill, MD. 21050</i> | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Lebanon Lutheran Cem.</i> | | Data
<i>2/12/97</i> | | 20c. Location - City or Town, State
<i>Red Lion, Pennsylvania</i> | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
<i>Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014</i> | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>PANCREATIC CANCER</i>
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
<i>9 mos</i> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>G.I. CHAD</i> | | 29c. License number
<i>D27730</i> | | 29d. Date signed (Month, Day, Year)
<i>2/10/97</i> | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>GAM CHEN, MD 6569 N. CHARLES ST. BALTIMORE MD 21204</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<i>FEB 12 1997</i> | | 32. Registrar's Signature
<i>J. Davidson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97 04095

DMMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04096

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert HAROLD Stolley, SR.

2. Date of Death

Month Day Year
FEBRUARY 9 1997

3. Time of Death

18:15

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-01-5149

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 30, 1902

9. Birthplace (State or Foreign Country)

CHANEY, FRANCE

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4631 ROKEBY ROAD

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WATCH MAKER

16b. Kind of Business/Industry

JEWELER

17. Father's Name (First, Middle, Last)

WILFRED STOLLEY

18. Mother's Name (First, Middle, Maiden Surname)

JENNY MAE LUFBERY

19a. Informant's Name/Relationship (Type, Print)

SANDRA E. BARANSKI (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2500 SYKESVILLE ROAD - WESTMINSTER, MD 21157

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

2/13/97

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.
4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 DAYS

b.

SEPTIC ARTHRITIS

Due to (or as a consequence of):

14 DAYS

c.

ASPIRATION PNEUMONIA

Due to (or as a consequence of):

14 DAYS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

PO 9140

29d. Date signed (Month, Day, Year)

FEBRUARY 9 - 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MUNIR RAHAL, ST. AGNES HOSPITAL, 900 CATON AVE, BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

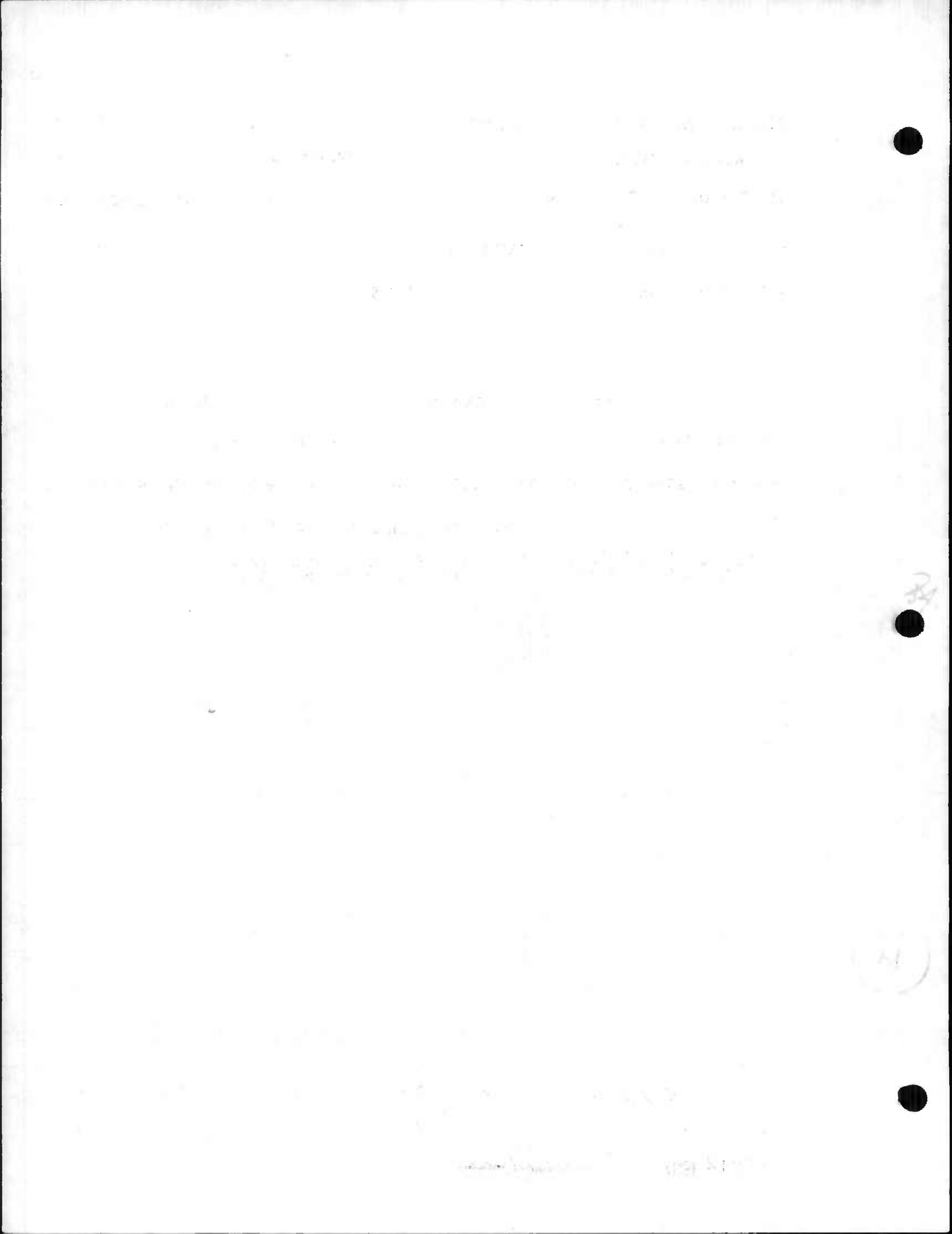
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a, b, c, d, e, f per MEO G-745 ^{1/15/97 reb} Certificate of Death

Reg. No.

97 04097

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

TYRONE L. TAYLOR

2. Date of Death

February 7, 1997

3. Time of Death

1146a

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

215-46-9842

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 7, 1947

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4615 Park Heights Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Foster

19a. Informant's Name/Relationship (Type, Print)

Niki Deanda - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9639 Lambeth Court Columbia, Md 21046

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arbutus Memorial Park

Date

2-11-97

20c. Location - City or Town, State

Arbutus, Md

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

March Funeral Home - West
4300 Wabash Ave Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

SEIZURE COMPLICATING HEAD INJURY

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☒ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

found 11/30/96

28b. Time of Injury

unknown M

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

unknown [police report #8k-19657]

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

3026 W. North Ave.

Baltimore, Md.

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February, 08, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of the death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04098

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Stewart Tolley, Sr.

2. Date of Death

February 5, 1997

3. Time of Death

9:00 p.m.

4a. Facility Name (If not institution, give street and number)

9514 Perry Brook Court

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

220-42-8264

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 26, 1944

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9514 Perry Brook Court

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th grade

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Improvement Contractor

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Marion R. Tolley

18. Mother's Name (First, Middle, Maiden Surname)

Regina L. Nicholas

19a. Informant's Name/Relationship (Type, Print)

Carol Tolley (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9514 Perry Brook Ct., Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gardens of Faith Cem.

Date

2/8/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Coronary Artery Disease

Due to (or as a consequence of):

b. Diabetes Mellitus - on insulin

Due to (or as a consequence of):

c. Renal Failure

Due to (or as a consequence of):

d. Peripheral Vascular Disease w/ R. foot gangrene

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier
(Check only
one)1 ☒2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23 ☐24 ☐25 ☐26 ☐27 ☐28 ☐29 ☐30 ☐31 ☐32 ☐33 ☐34 ☐35 ☐36 ☐37 ☐38 ☐39 ☐40 ☐41 ☐42 ☐43 ☐44 ☐45 ☐46 ☐47 ☐48 ☐49 ☐50 ☐51 ☐52 ☐53 ☐54 ☐55 ☐56 ☐57 ☐58 ☐59 ☐60 ☐61 ☐62 ☐63 ☐64 ☐65 ☐66 ☐67 ☐68 ☐69 ☐70 ☐71 ☐72 ☐73 ☐74 ☐75 ☐76 ☐77 ☐78 ☐79 ☐80 ☐81 ☐82 ☐83 ☐84 ☐85 ☐86 ☐87 ☐88 ☐89 ☐90 ☐91 ☐92 ☐93 ☐94 ☐95 ☐96 ☐97 ☐98 ☐99 ☐100 ☐101 ☐102 ☐103 ☐104 ☐105 ☐106 ☐107 ☐108 ☐109 ☐110 ☐111 ☐112 ☐113 ☐114 ☐115 ☐116 ☐117 ☐118 ☐119 ☐120 ☐121 ☐122 ☐123 ☐124 ☐125 ☐126 ☐127 ☐128 ☐129 ☐130 ☐131 ☐132 ☐133 ☐134 ☐135 ☐136 ☐137 ☐138 ☐139 ☐140 ☐141 ☐142 ☐143 ☐144 ☐145 ☐146 ☐147 ☐148 ☐149 ☐150 ☐151 ☐152 ☐153 ☐154 ☐155 ☐156 ☐157 ☐158 ☐159 ☐160 ☐161 ☐162 ☐163 ☐164 ☐165 ☐166 ☐167 ☐168 ☐169 ☐170 ☐171 ☐172 ☐173 ☐174 ☐175 ☐176 ☐177 ☐178 ☐179 ☐180 ☐

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04099

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Eileen Christine Toomey | | | | 2. Date of Death
Month Day Year
FEB. 9, 1997 | | 3. Time of Death
8:05pm | |
| | 4a. Facility Name (If not institution, give street and number)
9852 Old Annapolis Road | | | | 4b. City, Town, or Location of Death
Ellicott City | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
161-40-9956 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
48 Yrs. | | 8. Date of Birth (Month, Day, Year)
DEC 7, 1948 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Ellicott City | |
| Usual Residence of Decedent | | 10e. Street and Number
9852 Old Annapolis Road | | 10f. Zip Code
21042 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | 16b. Kind of Business/Industry
Child Psychology/
Hospital | | | | |
| 17. Father's Name (First, Middle, Last)
Vincent James Toomey | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Esther Bubeck | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret Collins/sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9852 Old Annapolis Rd., Ellicott City, MD 21042 | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 2/11/97 | | 20c. Location - City or Town, State
Baltimore, MD | | | | |
| 21. Signature of Funeral Service Licensee
Dawn F. McDonald | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Pancreatic Cancer
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
8 months | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Nicholas Koutrelakos | | 29c. License number
D3850a | | 29d. Date signed (Month, Day, Year)
February 10 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
NICHOLAS KOUTRELAKOS 11065 Little Paxton Pkwy Columbia Maryland 21044 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
Julia Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04100

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|--|---|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN NORMAN TRIMPER, SR. | | | | 2. Date of Death
Month FEBRUARY Day 10 , Year 1997 | | 3. Time of Death
5:35 AM | |
| | 4a. Facility Name (If not Institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-10-9318 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
FEB 3, 1918 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Arbutus | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
5222 Arbutus Avenue | | | | 10f. Zip Code
21227 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 10/45- | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12)
8 | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Lithographer | | 16b. Kind of Business/Industry
Printing | | | |
| | 17. Father's Name (First, Middle, Last)
Herman Trimper | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Agnes Spano | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Helen L. Trimper/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5222 Arbutus Ave., Baltimore, MD 21227 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | Date
2/11/97 | | 20c. Location - City or Town, State
Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
Dawn F. McDonald | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Kevin H. Schragas | | 29c. License number
D38543 | | 29d. Date signed (Month, Day, Year)
February 10, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
KEVIN H. SCHRAGAS 900 CATON AVENUE BALTIMORE, MARYLAND 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | | | 32. Registrar's Signature
John Davidson-Rendell | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04101

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE E VIA

2. Date of Death

Month Day Year
FEBRUARY 8, 1997

3. Time of Death

5:45 pm

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

RIVERVIEW NURSING CENTRE, INC

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

224-01-0728

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 30, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3550 McShane Way

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 yrs.

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

George Colvin

18. Mother's Name (First, Middle, Maiden Surname)

Annie Bleauford

19a. Informant's Name/Relationship (Type, Print)

Charles E. Via Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3550 McShane Way Dundalk Md. 21222

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Community Mem. Cem.

Date

2-12

20c. Location - City or Town, State

Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk

7110 Sollers Point Rd. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA

10 DAYS

Due to (or as a consequence of):

b. BONE MARROW FAILURE

2 MONTHS

Due to (or as a consequence of):

c. LUNG MASS

Due to (or as a consequence of):

d. BREAST MASS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, CORONARY DISEASE,

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Jim Parshall M.D.

D40008

2/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JIM PARSHALL 9105 FRANKLIN SQUARE DRIVE, BALTIMORE, M.D.

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Jane Davidson-Parshall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04102

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mollie Esther Williams

2. Date of Death

February 9 1997 06:32

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

135-24-9914

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 6, 1947

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2524 Loyola Southway

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Scouting Clerk

16b. Kind of Business/Industry

Social Security Admin

17. Father's Name (First, Middle, Last)

Hanson Alston

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Burnett

19a. Informant's Name/Relationship (Type, Print)

Ruth Burnett - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2524 Loyola Southway Balto, md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

20c. Location - City or Town, State

245-97 Randallstown, md

21. Signature of Funeral Service Licensee

Plymus B. Starnes

22. Name and Address of Facility

March F. A. West
4300 Wabash Avenue Balto, md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive cardiomyopathy
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension
Due to (or as a consequence of):c. End stage Renal Disease
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Anoxic Injury to Central Nervous System

2° to cardiac Arrest

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

L. Cunningham md

29c. License number

AS2402321LC9031

29d. Date signed (Month, Day, Year)

February 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Cunningham

Sinai Hospital

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

J. W. Wadsworth-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020. The law requires that the death certificate be executed by the attending physician and signed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04103

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **ERNEST Wooten JR.** 2. Date of Death Month **February** Day **8** Year **1997** 3. Time of Death **17:20**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **Sinai Hospital of Baltimore** 4b. City, Town, or Location of Death **Baltimore** 4c. County of Death **NA**

5. Social Security Number **238-28-7894** 6. Sex **1** M **2** F **3** Other **81** Yrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Apr. 6, 1915** 9. Birthplace (State or Foreign Country) **N.C.**

Usual Residence of Decedent 10a. State **md** 10b. County **NA** 10c. City, Town or Location **Baltimore** 10d. Inside City Limits **1** Yes **2** No

10e. Street and Number **4116 Norfolk Ave.** 10f. Zip Code **21216** 10g. Citizen of What Country? **USA**

11. Marital Status **1** Never Married **2** Married **3** Widowed **4** Divorced 12. Was Decedent Ever in U.S. Armed Forces? **1** Yes **2** No **3** If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **1** Yes **2** No Specify: 14. Race - American Indian, Black, White, etc. Specify: **Black**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12th** College (1-4 or 5+) **NA** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Pastor** 16b. Kind of Business/Industry **Church**

17. Father's Name (First, Middle, Last) **ERNEST WOOTEN SR.** 18. Mother's Name (First, Middle, Maiden Surname) **ANNIE WOOTEN**

19a. Informant's Name/Relationship (Type, Print) **Maryl Wooten - Wife** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **4116 Norfolk Ave. Balto md. 21216**

20a. Method of Disposition **1** Burial **2** Cremation **3** Removal from State **4** Donation **5** Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Woodlawn Cemetery** 20c. Location - City or Town, State **2-14-97 Baltimore, md**

21. Signature of Funeral Service Licensee **Blayus B. Harris** 22. Name and Address of Facility **March Funeral Home - West, 21215 4300 Wabash Ave. Balto. md.**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **sepsis** Due to (or as a consequence of): 23b. Approximate Interval Between Onset and Death **2 weeks**

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of): Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? **1** Yes **2** No **3** Probably **4** Unknown

24a. Was an autopsy performed? **1** Yes **2** No 24b. Were autopsy findings available prior to completion of cause of death? **1** Yes **2** No

25. Was case referred to medical examiner? **1** Yes **2** No 26. Place of Death (Check only one) Hospital: **1** Inpatient **2** ER/Outpatient **3** DOA Other: **4** Nursing Home **5** Residence **8** Other (Specify)

27. Manner of Death **1** Natural **2** Accident **3** Suicide **4** Homicide **5** Pending investigation **6** Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? **1** Yes **2** No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) **2** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **2** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **R. Kle MD** 29c. License number **AS2402321RK9039** 29d. Date signed (Month, Day, Year) **February 8th, 1997**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **Robyn Klein, MD Sinai Hospital of Baltimore 2401 Belvedere Baltimore, MD 21215**

31. Date filed (Month, Day, Year) **February FEB 12 1997** 32. Registrar's Signature **Gina Davidson-Randall**

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04104

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Madeline Wynn

2. Date of Death
Month Day Year

2

9

97

3. Time of Death
10 12 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Geriatric Ctr

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

MD

Funeral
Director

5. Social Security Number

051-28-9486

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

July 29, 1932

9. Birthplace (State or Foreign
Country)

VA

Usual Residence of Decedent

10a. State
MD

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

111 Main St.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Masters Degree

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Baltimore

17. Father's Name (First, Middle, Last)

William G. Marble

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Sue Nunnally

19a. Informant's Name/Relationship (Type, Print)

Rev. Andrew Wynn/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Main St. Balto, Md 21222

20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Mitchell Cemetery

Date

2-12

20c. Location - City or Town, State

Chase City, VA

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home
1701 Laurens St. Balto. Md 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Ventricular Arrhythmia

Due to (or as a consequence of):

b. Dilated Cardiomyopathy

Due to (or as a consequence of):

c. HTN

Due to (or as a consequence of):

d. Leukemoid Reaction

Approximate
Interval Between
Onset and Death

5 min

1-2 yrs

20 yrs

not known

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARDS CHF
Hypertension
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W.B. Conner

29c. License number

D04383

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.B. Conner MD

316C 5505 Hopkins Regan Circle
Baltimore MD 21224

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Adison Rendella

State
Registrar

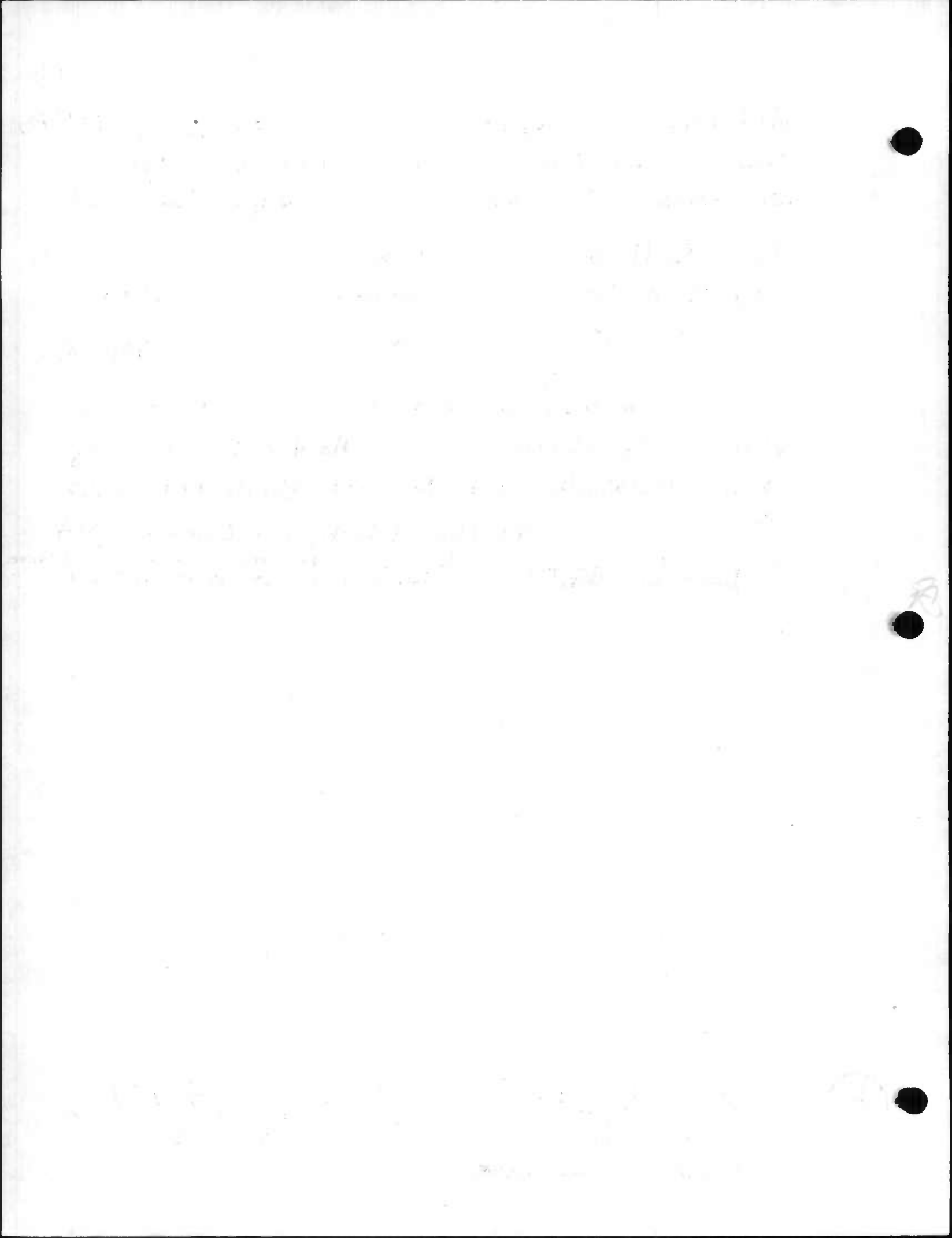
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04105

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frances M. Webster

2. Date of Death

February 6, 1997

3. Time of Death

7:50 AM

4a. Facility Name (If not institution, give street and number)

4116 Kahlston Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

219-16-3032

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 22, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4116 Kahlston Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ludwig E. Dobry

18. Mother's Name (First, Middle, Maiden Surname)

Frances M. Hudecek

19a. Informant's Name/Relationship (Type, Print)

Carpenter J. Webster (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4116 Kahlston Road, Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

2/10/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D14793

29d. Date signed (Month, Day, Year)

2/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9618 Balair Road Baltimore Md 21236

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04 106

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT WALLACE | | | | 2. Date of Death
Month 2 Day 11 Year 97 | | 3. Time of Death
3:30AM | |
| | 4a. Facility Name (If not institution, give street and number)
VA Maryland HealthCare System | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
219-03-6013 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth
Month 10 Day 30 Year 16 | |
| | 9. Birthplace (State or Foreign Country)
Md. | | 10a. State
Md. | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1921 Kennedy Avenue | | 10f. Zip Code
21202 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
6th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic | | 16b. Kind of Business/Industry
Kerr McGee Co. | | | |
| | 17. Father's Name (First, Middle, Last)
Robert Wallace | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosena Carter | | 19a. Informant's Name/Relationship (Type, Print)
Shirley Saunders | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1215 Beaumont Avenue Baltimore, Md. 21202 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA Cem. 02-18-97 Owings Mills | | 20c. Location - City or Town, State
Md. | | | |
| | 21. Signature of Funeral Service Licensee
Bernard D. Johnson | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Cardiopulmonary arrest
Due to (or as a consequence of):
b. malignant Right Pleural Effusion
Due to (or as a consequence of):
c. Metastatic Bladder Cancer
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Parshad MD | | 29c. License number
P10215 | | 29d. Date signed (Month, Day, Year)
2.11.97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sulekha Parshad, M.D., 10N. Greene St., Balto, Md. 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
Judy Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit certificate filed in by the funeral director.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04107

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--------------------------------------|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Harry Wolf | | | | 2. Date of Death
Month Feb. Day 3 Year 1997 | | 3. Time of Death
11:10 am | |
| | 4a. Facility Name (If not institution, give street and number)
93 Dundalk Ave. | | | | 4b. City, Town, or Location of Death
Dundalk | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
213-18-0425 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 6, 1911 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
93 Dundalk Ave. | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 yrs | | College (1-4 or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Baker | | 16b. Kind of Business/Industry
Bakery | |
| | 17. Father's Name (First, Middle, Last)
John Wolf | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Beatty | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Priscilla Sando | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
93 Dundalk Ave. Dundalk Md. 21222 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematorium, or other place)
Oak Lawn Cem. | | Date
2-5 | | 20c. Location - City or Town, State
Baltimore | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Connolly Funeral Home Of Dundalk
7110 Sollers Point Rd. 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Immediate Cause (Final disease or condition resulting in death)

 e. Pulmonary Hypertension
 Due to (or as a consequence of):
 b. Cardiomyopathy
 Due to (or as a consequence of):
 c. Hepatic Cirrhosis
 Due to (or as a consequence of):
 d. </div> <div style="width: 35%; text-align: center;"> Approximate Interval Between Onset and Death
 1 year
 2 years
 2 years </div> </div> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 MD | | | | 29c. License number
043427 | | 29d. Date signed (Month, Day, Year)
2/5/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. DEJONGE MD Johns Hopkins Bayview Medical Center BALTO. City | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04108

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH MARGUERITE WILLINGMYRE

2. Date of Death

Month Day Year
Feb. 5, 1997

3. Time of Death

5 a.m.

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

213-48-7392

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-22-1908

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6334 Cedar Lane

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

George P. Bewley

18. Mother's Name (First, Middle, Maiden Surname)

Katinka B. (Bonnet)

19a. Informant's Name/Relationship (Type, Print)

George Willingmyre (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1012 Parrs Ridge Drive, Spencerville, MD. 20868

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

2/6/97

20c. Location - City or Town, State

Beltsville, MD.

21. Signature of Funeral Service Licensee

► *Heide L. Lemmer*

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

5555 Twin Knolls Rd., Columbia, Md. 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicidal4 ☐ Homicidal5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *G. C. Prada*

29c. License number

D22587

29d. Date signed (Month, Day, Year)

February 5, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Gary C. Prada, 11055 Little Patuxent Parkway, Columbia, Md. 21044

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

► *Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04109

| | | | | | | | | |
|---|---|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
INA WILSON | | | | 2. Date of Death
Month Day Year
February 6, 1997 | | 3. Time of Death
10:00AM | |
| | 4a. Facility Name (If not institution, give street and number)
1023 Marksworth Road | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-09-3799 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
81 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 26, 1915 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
1023 Marksworth Road | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Collage (1-4or 5+)
Sales Clerk | | 16b. Kind of Business/Industry
Retail | | | |
| | 17. Father's Name (First, Middle, Last)
Anthony Stolarski | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helena Dombrowski | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Cynthia Brown (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5827 Bell Blvd. Bayside, New York 11364 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery | | 20c. Location - City or Town, State
Baltimore, Maryland | | 20d. Date
Feb. 10, 1997 | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. HYPERCHOLESTEROLEMIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CEREBROVASCULAR ACCIDENT
BRONCHITIS | | | | | | | |
| | 23c. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D40012 | | 29d. Date signed (Month, Day, Year)
February 6, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Scott Parson 4600 WILSON AVE, SUITE 107, BALTIMORE, MD 21229 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04110

ITEM:1 per DR.G-744 2-27-97 eoh

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last) <u>ANNA PHYLLIS WEBER</u>
<u>Phyllis Anna Weber</u> | | | | 2. Date of Death
Month <u>February</u> Day <u>6</u> Year <u>1997</u> | | 3. Time of Death
<u>10:00 AM</u> | | |
| | 4a. Facility Name (If not Institution, give street and number)
<u>Charlottesville Care Center</u> | | | | 4b. City, Town, or Location of Death
<u>Catonsville</u> | | 4c. County of Death
<u>Baltimore</u> | | |
| Funeral
Director | 5. Social Security Number
<u>214-34-3660</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
<u>86</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<u>8/11/1910</u> | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>MD</u> | 10b. County
<u>Baltimore</u> | 10c. City, Town or Location
<u>Catonsville</u> | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
<u>715 Maiden Choice Lane</u> | | | | 10f. Zip Code
<u>21228</u> | | 10g. Citizen of What Country?
<u>U.S.A</u> | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
<u>Elementary/Secondary (0-12)</u>
<u>10</u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Homemaker</u> | | 16b. Kind of Business/Industry
<u>Own Home</u> | | | | |
| | 17. Father's Name (First, Middle, Last)
<u>Charles Richter</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Mary Louise Schwartz</u> | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<u>Edward J. Weber/ SON</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>15-B-1 President Point Dr. Annapolis, MD 21403</u> | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Loudon Park</u> | | Data
<u>2/11/1997</u> | | 20c. Location - City or Town, State
<u>Maryland</u> | | |
| | 21. Signature of Funeral Service Licensee
<u>R. Craig W. Hef</u> | | | | 22. Name and Address of Facility
<u>Witzke Funeral Homes 21228</u>
<u>1630 Edmondson Avenue Catonsville, MD</u> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<u>Pneumonia</u> | | | | | | | Approximate Interval Between Onset and Death
<u>Days</u> | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>[Signature]</u> MD | | 29c. License number
<u>047447</u> | | 29d. Date signed (Month, Day, Year)
<u>February 9, 1997</u> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Andrew Lazaris 711 Maiden Choice Lane Catonsville, Maryland</u> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>FEB 12 1997</u> | | | | 32. Registrar's Signature
<u>J. Davidson-Randall</u> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04111

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alma B. Whittlif

2. Date of Death

Month

Day

Year

02 11 1997

3. Time of Death

0300

Funeral
Director

4a. Facility Name (If not institution, give street and number)

St. Elizabeth's Rehab. & Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-10-4436

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 27, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3320 Benson Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Church Organist

16b. Kind of Business/Industry

Lutheran

17. Father's Name (First, Middle, Last)

Bror Carl Bladin

18. Mother's Name (First, Middle, Maiden Surname)

Maria Sophia Diehl

19a. Informant's Name/Relationship (Type, Print)

Doris Whittlif Benson/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

238 Pondfield Rd. West, Bronxville, NY 10708

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc. 2/11/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Laurence R. Gallagher

29c. License number

DO 1786

29d. Date signed (Month, Day, Year)

FEB 11 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAURENCE R. GALLAGHER, MD 719 MAIDENCHOICE LANE, BALTO, MD 21228

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04112

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE M. WHEELER

2. Date of Death

Month

Day

Year

February 7 1997

3. Time of Death

9:40 A.M.

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

215-14-6614

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 26, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6650 Whitmore Ct., Apt. 149

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical Worker

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Owen Richard Clark

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Lois Jordan

19a. Informant's Name/Relationship (Type, Print)

Judith E. Tindle / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

974 Point Pleasant Rd., Glen Burnie, MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Pk.

Date

February

10, 1997

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home

421 Crain Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

243977

29d. Date signed (Month, Day, Year)

February 7 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CYNTHIA OKENWIST, 301 HOSPITAL DRIVE, GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

21.

to 8 to 1000 ft. (approx.)

Copy 5 of 1000

These are the only copies of the original now left. The original was destroyed by fire in 1875.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04113

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE T.

ZNAMIROWSKI

2. Date of Death

Month
FEBDay
5thYear
1997

3. Time of Death

5:40AM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-14-5648

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month Day Year
Feb. 7, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1105 Hendrix Court

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

AMERICAN POLISH
Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Frank Tadkowski

18. Mother's Name (First, Middle, Maiden Surname)

Katie Lewandowski

19a. Informant's Name/Relationship (Type, Print)

Isadore M. Znamirovski (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1105 Hendrix Court, Bel Air, MD. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Rosary Cemetery

Date

2/8/97

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

RESPIRATORY FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

b.

SEPSIS

Due to (or as a consequence of):

2 WEEKS

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BREAST CARCINOMA WITH METASTASIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MEDICAL DOCTOR

29c. License number

P09306

29d. Date signed (Month, Day, Year)

FEB 5th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KWASHIE ATTORNEY THE GOOD SAMARITAN HOSPITAL OF MARYLAND INC.

31. Date filed (Month, Day, Year)

FEB 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

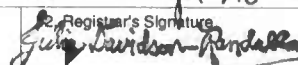
97 04114

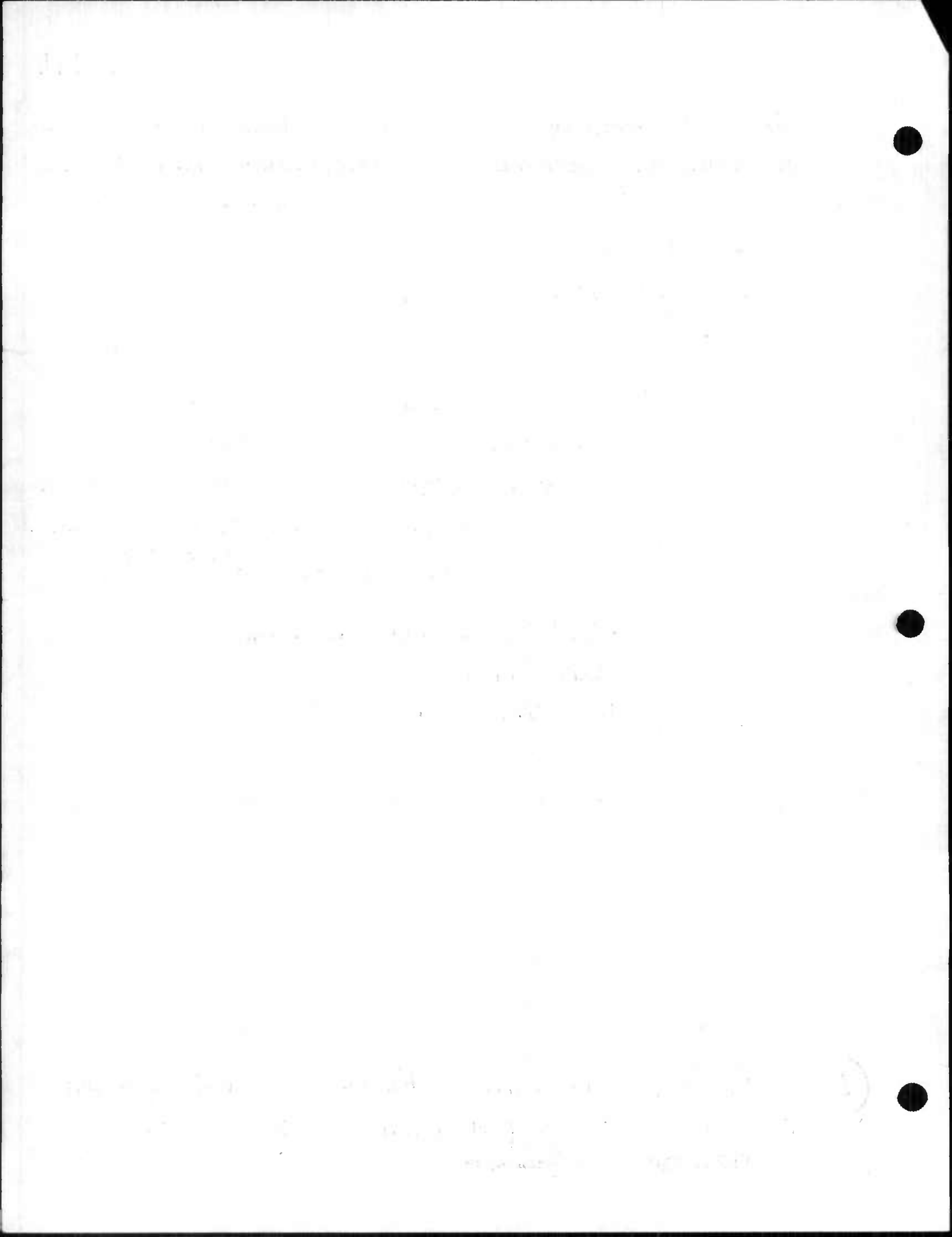
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN E. ARCHIBALD, JR. | | | | 2. Date of Death
Month FEBRUARY Day 11 Year 1997 | | 3. Time of Death
2:10 AM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
219 54 2770 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
44 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 5, 1952 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
1111 Double Chestnut Court | | | |
| | 10f. Zip Code
21226 | | | | 10g. Citizen of What Country?
U.S. | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th College (14 or 5+) Collega | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | 16b. Kind of Business/Industry
Carpentry | | | |
| | 17. Father's Name (First, Middle, Last)
John E. Archibald Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Green | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
John E. Archibald Sr. /father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1111 Double Chestnut Ct. Baltimore, Maryland 21226 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | 20c. Location - City or Town, State
2/12/97 Baltimore, Maryland | | 21. Signature of Funeral Service Licensee
 | |
| | 22. Name and Address of Facility
Gonce Funeral Home P.A. | | 22. Name and Address of Facility
4001 Ritchie Highway Baltimore, Md. 21225 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. ACUTE SUBARACHNOID HEMORRHAGE
Due to (or as a consequence of):
b. SEVERE ANAEMIA
Due to (or as a consequence of):
c. LOBAR PNEUMONIA
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death
1 WEEK
1 WEEK
1 WEEK | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and Title of Certifier
 Physician | | | | |
| 29c. License number
045149 | | | | 29d. Date signed (Month, Day, Year)
February 11 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Onozoga B. 301 Hospital Drive GLEN BURNIE, MARYLAND | | | | 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | |
| 32. Registrar's Signature
 | | | | 33. Registrar's Number
21061 | | | | |



97 04115

ITEM: 23 part 1 perDR. G-744 2-13-97 eoh

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Beatrice Baldwin S</i> | | | | 2. DATE OF DEATH
MONTH <i>1</i> DAY <i>30</i> YEAR <i>97</i> | | 3. TIME OF DEATH
<i>12:15A</i> M | |
| 4. SOCIAL SECURITY NUMBER
<i>213-30-9342</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>90</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>Sept. 24, 1906</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Virginia</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>Center Annapolis Nursing & Rehabilitation</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Annapolis</i> | |
| 9c. COUNTY OF DEATH
<i>Anne Arundel</i> | | | | 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Anne Arundel</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Annapolis</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>900 Van Buren Street</i> | |
| 10f. ZIP CODE
<i>21403</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | |
| 14. RACE — American Indian, Black, White, etc.
Specify: <i>white</i> | | | | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i> | | | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Office Manager</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>unknown</i> | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>James Hollis Stone</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Alice Sarah Pettigrew</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Norman A. Baldwin/Son</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>630 Americana Drive, Annapolis, MD 21403</i> | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Ronald S. Wade, Director</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i>
a. DUE TO (OR AS A CONSEQUENCE OF):
b. <i>DIABETES MELLITUS</i>
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. <i>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</i> | | | | | | | Approximate interval Between Onset and Death
<i>3 mos.</i> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Recent undetected Hypertension</i> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>R. L. Hochman, MD</i> | | | | 29c. LICENSE NUMBER
<i>005192</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>1/30/97</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Richard I. Hochman, MD 1833 A Forest Dr, Annapolis, Md 21401</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 13 1997</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Aug 1860

1861

1862

1863

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04116

| | | | | | |
|---|--|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES CHRISTOPHER BASILE | | 2. Date of Death
Month FEB. Day 10 Year 1997 | | 3. Time of Death
6:26 PM. |
| | 4a. Facility Name (If not institution, give street and number)
24 BRISTOL AVE | | 4b. City, Town, or Location of Death
BROOKLYN | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
375 50 5170 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
49 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
June 1, 1947 | | 9. Birthplace (State or Foreign Country)
Michigan | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | |
| | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
24 Bristol Avenue | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 years | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | | 16b. Kind of Business/Industry
Dixie Company |
| | 17. Father's Name (First, Middle, Last)
James Basile | | 18. Mother's Name (First, Middle, Maiden Surname)
Dorene Bronson | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ae S. Basile / wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24 Bristol Avenue Baltimore, Maryland 21225 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cemetery | | 20c. Location - City or Town, State
2/15/97 Baltimore, Maryland |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Finest disease or condition resulting in death)
a. Atherosclerosis Cardiovascular disease
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
FEB. 11, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | | |
| 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04117

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN M BRANDT

2. Date of Death

February 12 1997

3. Time of Death

9:40 A.M.

4a. Facility Name (If not institution, give street and number)

North ARUNDEL Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

217 16 6089

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 25, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

343 Dublin Drive

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

8th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Pestridge

18. Mother's Name (First, Middle, Maiden Summa)

Helen Bayner

19a. Informant's Name/Relationship (Type, Print)

Charles Brandt / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

343 Dublin Drive Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Glen Haven Mem. Park

Date

2/14/97

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Richard J. Gonce

22. Name and Address of Facility

Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE CARDIOMYOPATHY

Due to (or as a consequence of):

b. FIBROCALCIFIC LUNG DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. J. Gonce MD

29c. License number

D435177

29d. Date signed (Month, Day, Year)

February 12 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela BREKUNO, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 04118**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedant's Name (First, Middle, Last)
Lawrence Nathaniel Bowman Sr. | | | | 2. Date of Death
Month 02 Day 09 Year 97 | | 3. Time of Death
7:54pm | |
| 4a. Facility Name (If not institution, give street and number)
2022 W. Fayette Street | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | |
| 5. Social Security Number
220-20-6133 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
07-06-27 | |
| 9. Birthplace (State or Foreign Country)
Md. | | 10a. State
Md. | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2022 W. Fayette Street | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedant Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedant's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade
College (1-4or 5+) NA | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Deacon | | 16b. Kind of Business/Industry
Sexton Church | | | |
| 17. Father's Name (First, Middle, Last)
James E. Bowman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ravine Farrar | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Deborah L. Johnson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2022 W. Fayette Street Baltimore, Md. 21223 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cem. | | 20c. Date
02-14-97 | | 20d. Location - City or Town, State
Baltimore, Md. | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
Wm. C. March FH 1101 E. North Avenue | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)
a. COLON CANCER
Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):</p> <p>c.
Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D29071 | | 29d. Date signed (Month, Day, Year)
2-11-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. KRISHNAN, MD 221 N. EUTAW ST #305 BALTIMORE 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

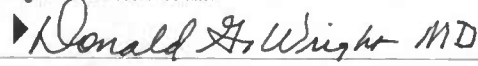
97 04119

Reg. No.

| | | | | | | | | |
|--|--|---|---|------------------------------------|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HERBERT BOWMAN | | | | 2. Date of Death
Month Day Year
JAN. 30, 1997 | | 3. Time of Death
0855 A | |
| | 4a. Facility Name (If not institution, give street and number)
MARYLAND GENERAL ER | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
219-22-3231 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 13, 1929 | |
| | 9. Birthplace (State or Foreign Country)
VIRGINIA | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1027 CATHEDRAL STREET APT. 5G | | 10f. Zip Code
21201 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WW 2
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TRUCK DRIVER | | 16b. Kind of Business/Industry
PRIVATE CO. | | | |
| | 17. Father's Name (First, Middle, Last)
ELIJAH BOWMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
HAZEL MASON | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
FRANCES GINYARD (SISTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4400 FAIRVIEW AVE. BALTO., MD 21216 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARRISON FOREST 2/7/97 | | 20c. Location - City or Town, State
OWINGS MILL, MD. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
IRVIN P. CARROLL F/H
1712 WEST NORTH AVE. 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
INSPECTED
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier

Donald A. Wright MD | | | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
JAN. 31, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DONALD WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

High Speed ...
...
... (10.8) ...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04120

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMANUEL (MANNIE) F. BERG, JR.

2. Date of Death

FEB. 11 1997

3. Time of Death

12:50 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-12-7619

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

OCT. 5, 1925

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2504 BLACKHAWK CIRCLE

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

EMANUEL

BERG, SR.

18. Mother's Name (First, Middle, Maiden Surname)

HENRIETTA

HECHT

19a. Informant's Name/Relationship (Type, Print)

ANNETTE BERG (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2504 BLACKHAWK CIRCLE BALTO., MD 21209

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW FRIENDSHIP

Date

2/12/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. pneumonia
Due to (or as a consequence of):

2 weeks

c. Metastatic renal cell carcinoma
Due to (or as a consequence of):

16 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

kidney transplant, Whipple procedure

seizure disorder

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46382

29d. Date signed (Month, Day, Year)

February 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Morsinger, MD 600 N. Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5221 1945
S. 12. 11. 1945
The day - 1945
S. 12. 11. 1945
S. 12. 11. 1945

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04121

Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Thomas Brown</u> | | 2. Date of Death
Month <u>February</u> Day <u>10</u> Year <u>1997</u> | | 3. Time of Death
<u>9:45 AM</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>Maryland General Hospital</u> | | 4b. City, Town, or Location of Death
<u>Baltimore City</u> | | 4c. County of Death
<u>NA</u> |
| Funeral
Director | 5. Social Security Number
<u>213-09-3771</u> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>82</u> Yrs. | If Under 1 Year
Months <u> </u> Days <u> </u> | If Under 24 Hrs.
Hours <u> </u> Min. <u> </u> |
| | 8. Date of Birth (Month, Day, Year)
<u>DEC. 25, 1914</u> | | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | |
| To Be Completed by Funeral Director | 10a. State
<u>Maryland</u> | | 10b. County
<u>NA</u> | | 10c. City, Town or Location
<u>BALTIMORE</u> |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
<u>1102 DRUID HILL AVE</u> | | 10f. Zip Code
<u>21217</u> | | 10g. Citizen of What Country?
<u>USA</u> |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <u>WWII</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u> </u> |
| 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>UNKNOWN</u> College (1-4 or 5+) <u> </u> | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>ROOFER</u> | | 16b. Kind of Business/Industry
<u>Private Company</u> | | | |
| 17. Father's Name (First, Middle, Last)
<u>BAYNON BENJAMIN BROWN</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>BERTHA FAIDLEY</u> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<u>MADELINE PULLEN, SISTER</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>702 N. CARROLLTON AVE BALTIMORE, MARYLAND 21217</u> | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u> </u> | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Garrison Forest Vet. Cem.</u> | | 20c. Location - City or Town, State
<u>Owings Mills, Maryland</u> | |
| 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | 22. Name and Address of Facility
<u>CHATMAN - HARRIS FUNERAL HOME</u>
<u>5240 REISTERSTOWN RD</u>
<u>BALTIMORE, MARYLAND 21115</u> | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <u>Acute myocardial infarction</u>
Due to (or as a consequence of):
b. <u>Coronary artery disease</u>
Due to (or as a consequence of):
c. <u> </u>
Due to (or as a consequence of):
d. <u> </u> | | Approximate Interval Between Onset and Death
<u>1 hour</u> | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Essential hypertension</u>
<u>Severe COPD</u>
<u>Lung tumor.</u> | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u> </u> | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
<u> </u> | | 28b. Time of Injury
<u> </u> M <u> </u> | |
| 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
<u> </u> | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
<u> </u> | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
<u> </u> | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner | | 29b. Signature and title of certifier
<u>Komal K. Dang M.D.</u> | | | |
| 29c. License number
<u>D18362</u> | | 29d. Date signed (Month, Day, Year)
<u>Feb., 11, 1997.</u> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>KOMAL K. DANG M.D., 3455, Wilkens Ave, Suite 308, Balto., Md 21229</u> | | | | | |
| 31. Date filed (Month, Day, Year)
<u>FEB 13 1997</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04122

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Elaine Baker</u> | | 2. Date of Death
Month <u>FEBRUARY</u> Day <u>10</u> Year <u>1997</u> | | 3. Time of Death
<u>02:02AM</u> |
| | 4a. Facility Name (If not institution, give street and number)
<u>THE JOHNS HOPKINS HOSPITAL</u> | | 4b. City, Town, or Location of Death
<u>BALTIMORE CITY</u> | | 4c. County of Death
<u>n/a</u> |
| Funeral
Director | 5. Social Security Number
<u>215-34-9476</u> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>56</u> Yrs. | If Under 1 Year
Months <u> </u> Days <u> </u> | If Under 24 Hrs.
Hours <u> </u> Min. <u> </u> |
| | 8. Date of Birth (Month, Day, Year)
<u>Nov 11, 1940</u> | | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10e. State
<u>MD</u> | | 10b. County
<u>n/a</u> |
| | 10c. City, Town or Location
<u>Baltimore</u> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
<u>1733 Orleans Street</u> | | 10f. Zip Code
<u>21231</u> | | 10g. Citizen of What Country?
<u>USA</u> |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>High school</u>
College (1-4 or 5+) <u> </u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Social Worker</u> |
| | 16b. Kind of Business/Industry
<u>Dept of Social Service</u> | | 17. Father's Name (First, Middle, Last)
<u>Robert Simpson</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Beatrice Dailey</u> |
| | 19a. Informant's Name/Relationship (Type, Print) <u>son</u>
<u>Larry E. Simpson</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>6985 McClean Blvd. Baltimore, Maryland 21234</u> | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>MD Veteran Cemetery/Garrison</u> | | 20c. Location - City or Town, State
<u>Owings Mills, Maryland</u> |
| | 21. Signature of Funeral Service Licensed
<u>Ernest R. Terry Jr.</u> | | 22. Name and Address of Facility
<u>Nutter Funeral Homes, Inc.</u>
<u>2501 Gwynns Falls Parkway</u>
<u>Baltimore, Maryland 21216</u> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <u>Cardiac Arrest</u>
Due to (or as a consequence of):
b. <u>Atherosclerotic Vascular Disease</u>
Due to (or as a consequence of):
c. <u>Insulin-dependent diabetes</u>
Due to (or as a consequence of):
d. <u> </u> | | Approximate Interval Between Onset and Death
<u>Unknown</u>
<u>15 years</u>
<u>20 years</u> | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Renal Transplant</u> | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month/Day/Year)
<u>N/A</u> | | 28b. Time of Injury
<u>M</u> | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>Douglas P. Stacey MD</u> | | 29c. License number
<u>D47241</u> | 29d. Date signed (Month, Day, Year)
<u>February 10, 1997</u> |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Douglas P. Stacey MD 600 N Wolfe St. Baltimore MD</u> | | 31. Date of Death (Month, Day, Year)
<u>FEB 13 1997</u> | | | |
| 32. Registrar's Signature
<u>John Anderson-Randall</u> | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04123

ITEM: 19a PER FH G-744 2-13-97 eoh

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedant's Name (First, Middle, Last)
YEVGENIA BIRGER | | 2. Date of Death
Month FEB. 11, Day 1997 Year | | 3. Time of Death
5:30am |
| | 4a. Facility Name (If not institution, give street and number)
MILFORD MANOR NURSING HOME | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
212-59-7006 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
FEB. 23, 1915 | | 9. Birthplace (State or Foreign Country)
UKRAINE | | |
| To Be Completed by Funeral Director | Usual Residence of Decedant | | | | |
| | 10e. State
MARYLAND | 10b. County
BALTIMORE | 10c. City, Town or Location
OWINGS MILLS | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
116 RICHMAR RD., APT. I | | 10f. Zip Code
21117 | | 10g. Citizen of What Country?
UKRAINE |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | |
| | 17. Father's Name (First, Middle, Last)
AARON SOKOLOVSKY | | 18. Mother's Name (First, Middle, Maiden Surname)
CLARA UNAVAILABLE | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ALEKSANDR DR ALEKSANDR BIRGER (GRANDSON) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 RICHMAR RD., APT. I OWINGS MILLS, MD 21117 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HILLTOP SERVICE CORP. | | 20c. Location - City or Town, State
2/12/97 TOWSON, MD |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 Reisterstown Road Pikesville, MD 21208 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. Polycythemia Rubra Vera
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
3 years |
| | b. Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D27034 | | 29d. Date signed (Month, Day, Year)
February 12, 1997 |
| | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
Ra Hude Copekind MD 5310 Old Court Road Randallstown MD 21133 | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

For the purpose of the present investigation, the following data were obtained from the records of the Bureau of the Census, Department of Commerce, for the years 1929-1931.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04124

ITEM: 24a G-744 2-13-97 eoh per DR.

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|--|--|---|---|-----------------------------------|---|--|--|--|---|----|-----------------------|---|----|---|----|---|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Albert Francis Carnes | | | | 2. Date of Death
Month Day Year
Feb. 7, 1997 | | 3. Time of Death
12:20 am | | | | | | | | | | |
| | 4e. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
218-26-5465 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
65 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Mar 24, 1931 | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | 10e. Street and Number
1516 Cox Street | | | 10f. Zip Code
21211 | | 10g. Citizen of What Country?
U.S.A | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Warehouseman | | | 16b. Kind of Business/Industry
Best Way Distr. Co. | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Martin Carnes | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elsie Tase | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Darleen Smith (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2030 Daybreak Circle, Harrisburgh, Pa 17110 | | | | | | | | | | | | |
| | 20e. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem Pk. | | Date
2/10/97 | | 20c. Location - City or Town, State
Elkridge, Maryland | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Md. 21211 | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>e.</td> <td>Myocardial infarction</td> <td rowspan="4"> Approximate Interval Between Onset and Death
 Minutes
 years
 years </td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):
Coronary artery disease</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):
Diabetes mellitus</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. | Myocardial infarction | Approximate Interval Between Onset and Death
Minutes
years
years | b. | Due to (or as a consequence of):
Coronary artery disease | c. | Due to (or as a consequence of):
Diabetes mellitus | d. |
| Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. | Myocardial infarction | Approximate Interval Between Onset and Death
Minutes
years
years | | | | | | | | | | | | | | |
| | b. | Due to (or as a consequence of):
Coronary artery disease | | | | | | | | | | | | | | | |
| | c. | Due to (or as a consequence of):
Diabetes mellitus | | | | | | | | | | | | | | | |
| | d. | Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D43615 | | 29d. Date signed (Month, Day, Year)
February 7, 1997 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Lois Killewich, M.D. 419 West Redwood Street 21201 | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04125

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|---|---|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GOLDIE COOPER | | | | 2. Date of Death
Month FEB Day 11 Year 1997 | | 3. Time of Death
1:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
LEVINDALE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-09-9262 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 6. Date of Birth (Month, Day, Year)
JUNE 2, 1919 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
3010 FALLSTAFF MANOR CT., APT. G | | | | 10f. Zip Code
21209 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
BUYER | | 16b. Kind of Business/Industry
STEWART'S DEPT. STORE | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
MAX COOPER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
FREDA UNKNOWN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MRS. DOROTHY LEAVEY (FRIEND) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6310 GREENSPRING AVE., APT. 303 BALTO., MD 21209 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON (CHIZUK AMUNO) | | Date
2/12/1997 | | 20c. Location - City or Town, State
BALTO., MD | |
| | 21. Signature of Funeral Service Licensee
<i>Jay Allen Lewis</i> | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Lung Disease
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death
YRS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
NA
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State
Registrar | 29b. Signature and title of certifier
<i>M. W. Mahoney MD</i> | | | | 29c. License number
D45757 | | 29d. Date signed (Month, Day, Year)
FEB 11, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATTHEW Mc NABNEY 2434 W Belvedere Balt, MD 21215 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | 32. Registrar's Signature
<i>John Davidson-Russell</i> | | | | |

97 04126

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
CLARA DE LOZIER | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 11 1997 | | 3. TIME OF DEATH
6:44 P M | |
| 4. SOCIAL SECURITY NUMBER
411 30 0967 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
91 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Feb. 25, 1905 | |
| 8. BIRTHPLACE (State or Foreign Country)
Mississippi | | | | 9a. FACILITY NAME (If not institution, give street and number)
Deaton Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | |
| 9c. COUNTY OF DEATH
N/A | | | | 10a. STATE
Maryland | | | |
| 10b. COUNTY
N/A | | | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | |
| 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
611 S. Charles Street | | | |
| 10f. ZIP CODE
21230 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 9th
College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Home Maker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Charles Ray | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Fannie Bigbee | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary Edwards / daughter | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1027 Cathedral Street Apt 7 G Balto., Md. 21201 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Meadowridge Memorial Pk. 2/14 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Richard E. Davis</i> | |
| 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A.
4001 Ritchie Hwy. Baltimore, Md. 21225 | | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction suspected

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST

a. Atherosclerotic heart disease
b. Hypertension
c. Chronic atrial fibrillation
d. Chronic renal failure on hemodialysis | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>[Signature]</i> | | | | 29c. LICENSE NUMBER
D 30494 | | 29d. DATE SIGNED (Month, Day, Year)
2/11/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
K. DESAIGNE 4660 Wilkoss Ave Balto MD 21229 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 13 1997 | | | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rendall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04127

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Melford D. Diedrick | | | | 2. Date of Death
Month Day Year
January 24 1997 | | 3. Time of Death
8:30 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis Elder Care Corsica Hills Facility | | | | 4b. City, Town, or Location of Death
Centreville | | 4c. County of Death
Queen Annes | |
| Funeral
Director | 5. Social Security Number
114-26-2641 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 24, 1912 | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Maryland | | 10b. County
Queen Annes | | 10c. City, Town or Location
Queenstown | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3201 Bennet Point Rd. | | 10f. Zip Code
21658 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: unknown | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
medical illustrator | | 16b. Kind of Business/Industry
medical | | | |
| | 17. Father's Name (First, Middle, Last)
Henry Diedrick | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Angaleana Gerloch | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Douglas Diederick/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3201 Bennett Point Rd., Queenstown, MD 21658 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Data | | 20c. Location - City or Town, State | | | |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Physician
/Medical
Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Helen A Noble MD | | | | 29c. License number
D46587 | | 29d. Date signed (Month, Day, Year)
2/10/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HELEN A NOBLE MD 122 SPEER RD CHESTERTOWN, MD 21620 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | 32. Registrar's Signature
[Signature] | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04128

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUSSELL JOHN DeGRAW, JR.

2. Date of Death

FEBRUARY 9, 1997

3. Time of Death

1:30 P.M.

4a. Facility Name (If not institution, give street and number)

62 ROCKYWOOD LANE

4b. City, Town, or Location of Death

BALTIMORE COUNTY

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

218-18-0590

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JANUARY 27, 1924

9. Birthplace (State or Foreign Country)

BALTIMORE, MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE COUNTY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

62 ROCKYWOOD LANE

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1942-194513. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
116. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

WESTERN ELECTRIC

17. Father's Name (First, Middle, Last)

RUSSELL JOHN DeGRAW, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET MARIE JAMISON

19a. Informant's Name/Relationship (Type, Print)

RUTH Z. DeGRAW (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

62 ROCKYWOOD LANE BALTIMORE, MARYLAND 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GARDENS OF FAITH CEMETERY FEBRUARY 13, 1997 BALTIMORE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ *bbather Obesah*

22. Name and Address of Facility

LASSAHN FUNERAL HOME, INC.

7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Chronic Obstructive Pulmonary Disease*
Due to (or as a consequence of):Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. *Sleep Apnea*
Due to (or as a consequence of):c. *Coronary Heart Failure*
Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *Carmen Salvateerra*

29c. License number

D33627

29d. Date signed (Month, Day, Year)

2-10-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CARMEN SALVATEERRA

1012 06 North Point Rd Parko MD 21224

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

*J. Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04 129

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Melvin

2. Date of Death

David Sr.

Feb

7 1997

3. Time of Death

1:50 PM

4a. Facility Name (If not institution, give street and number)

JOSEPH RICHIE HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-62-7975

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 24, 1955

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

21 SOUTH CULVER STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12thCollege (1-4or 5+)
4yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

YOUTH SUPERVISOR

16b. Kind of Business/Industry

Correction

17. Father's Name (First, Middle, Last)

ROBERT DAVID

18. Mother's Name (First, Middle, Maiden Surname)

HORESTINE BELL

19a. Informant's Name/Relationship (Type, Print)

ROSLYN-FAISON-DAVID (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 S. CULVER STREET BALTO, MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN STAR CEM

Date

2/12/97

20c. Location - City or Town, State

CATONSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAPLE FUNERAL SERVICE

5502 WINNER AVENUE BALTO, MD. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

END STAGE A.I.D.S

Approximate Interval Between Onset and Death

2 YRS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

INTRAVENOUS DRUG ABUSE

YEARS

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DISSEMINATED MYCOBACTERIUM INTERCELLULARE

C.M.V. COLITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 06933

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN B. MACGIBBON M.D.
101 W READ ST STE 719, MEDICAL ARTS BLDG BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrant's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04130

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MILDRED EBRON | | | | 2. Date of Death
Month February Day 10 Year 1997 | | | | 3. Time of Death
10:35pm | |
| | 4e. Facility Name (If not institution, give street and number)
Stella Maris--Mercy | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
218-87-5441 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
60 Yrs. | | 8. Date of Birth
(Month, Day, Year)
11-24-36 | | 9. Birthplace (State or Foreign Country)
NC | |
| | 10a. State
MD. | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
512 Glen Allen Road | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) NA | | | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic | | | 16b. Kind of Business/Industry
various trades | | |
| | 17. Father's Name (First, Middle, Last)
Sylvester Ebron | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Williams | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Cynthia Ebron | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
512 Glen Allen Road Baltimore, MD. 21229 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Mem. Pk. Cem | | 20c. Location - City or Town, State
02-14-97 Arbutus, Md. | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Baltimore, Md. 21202
WM.C. March FH 1101 E. North Avenue | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death)
METASTATIC CARCINOSARCOMA OF BILBLADDER | | | | | | | | Approximate Interval Between Onset and Death
18 mos | |
| | 23b. Due to (or as a consequence of):
Adrial Arrhythmia | | | | | | | | | |
| | 23c. Due to (or as a consequence of): | | | | | | | | | |
| 23d. Due to (or as a consequence of): | | | | | | | | | | |
| 23e. Due to (or as a consequence of): | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Adrial Arrhythmia | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D40480 | | 29d. Date signed (Month, Day, Year)
February 11, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FERNANDO J. FERRO, MD | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
5810 BELAIR RD
BALTO., MD 21206 | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04131

ITEM:1 perDR. G-744 2-13-97 eoh

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | |
|---|---|--|---|--|--|--------------------------------|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William R. Fillmore | | | | 2. Date of Death
Month Feb Day 08 Year 97 | | 3. Time of Death
14⁰⁰ | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | | | | | | |
| Funeral
Director | 5. Social Security Number
217-01-9583 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sep 16, 1912 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
1319 West Pratt Street | | | | | 10f. Zip Code
21223 | | 10g. Citizen of What Country?
U.S.A | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unk | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Consolidated Delivery | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Samuel Fillmore | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie McCauley | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Daniel Fillmore (Son) | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
821 Earl of Chesterfield La, Virginia Beach, Va. 23454 | | | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Mem Park | | Data
2/12/97 | | 20c. Location - City or Town, State
Sykesville, Md | | | | | | |
| 21. Signature of Funeral Service Licensee
A. Alan Seitz, Jr. | | | | | 22. Name and Address of Facility
A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Md. 21211 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Superior Venal Caval Obstruction
Dua to (or as a consequence of):
b. Atrial Fibrillation
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Dua to (or as a consequence of):
d.
Dua to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
24 hours
36 hours | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
Albert John Folgueras M.D. | | | | | | | 29c. License number
D44113 | | 29d. Date signed (Month, Day, Year)
February 08, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ALBERT JOHN FOLGUERAS, M.D.
413 Commonwealth Avenue
Baltimore, Maryland 21228 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | | | | | | | 32. Registrar's Signature
He Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

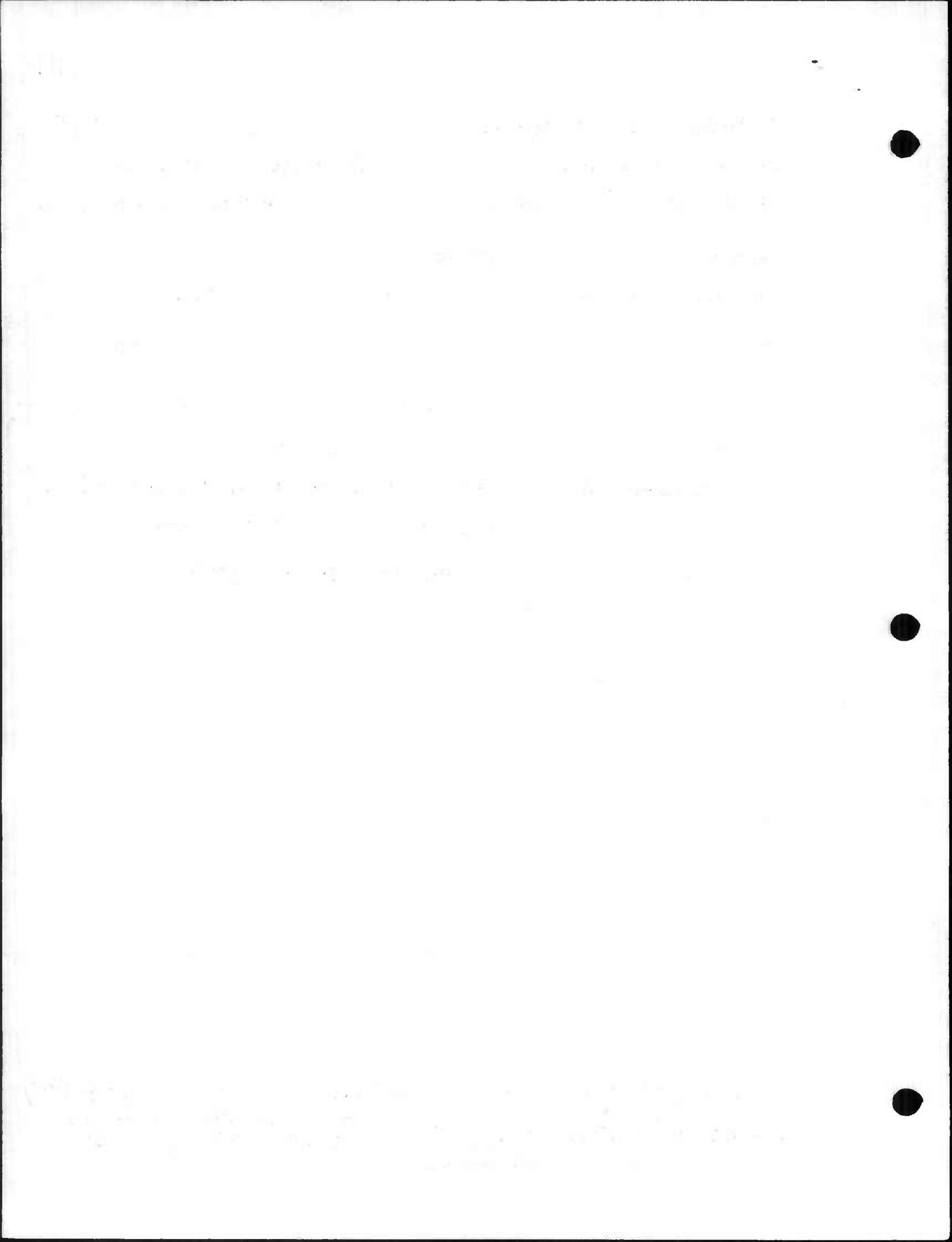
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04132

Certificate of Death

Reg. No.

ITEM: 1.7 per DR. G-744 2-13-97 eoh

| | | | | | | | | |
|---|---|---------------------------|---|---|---|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BELLE FELDMAN | | | | 2. Date of Death
Month FEB Day 6 Year 1997 | | 3. Time of Death
1-45 PM | |
| | 4a. Facility Name (If not institution, give street and number)
LEVINDALE | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
215-56-4207 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
OCT. 13, 1904 | 9. Birthplace (State or Foreign Country)
LITHUANIA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
7111 PARK HEIGHTS AVE., APT. 410 | | | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
OWN HOME | |
| | 17. Father's Name (First, Middle, Last)
ELI S. RUBENSTEIN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNA SCHWARTZ | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
DR. RICHARD LAVY (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13 KING CT. ANNAPOLIS, MD 21401 | | | |
| | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BNAI ISRAEL | | Date
2/7/1997 | | 20c. Location - City or Town, State
BALTIMORE, MD | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE DEMENTIA
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
ATTENDING PHYSICIAN | | | | 29c. License number
D25610 | | 29d. Date signed (Month, Day, Year)
FEB - 6 - 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LEVINDALE 2434 W. BELVERDERE AVENUE BALTIMORE MD 21215 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | 32. Registrar's Signature
 | | | | |

97-0642-510

B.K.S. Per MEO film G746 4-28-97 rja
Item 23a Part 2, 28abcdef 27

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04133

Items: 23 part I, 27 per MEO G-744 2/19/97 reb

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|---|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VERILEE GILLIAM | | | | 2. Date of Death
Month FEB. Day 9, Year 1997 | | 3. Time of Death
11:15 AM | |
| | 4a. Facility Name (If not institution, give street and number)
3805 DELVERNE ROAD | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
212-44-2556 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
50 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
07-08-46 | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
3805 Delverne Road | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
10th Grade | | Collage (1-4or 5+)
NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Thomas Truck Co. | |
| | 17. Father's Name (First, Middle, Last)
Overton Gilliam | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Irene Holmes | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Shirley Gilliam | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3805 Delverne Road Baltimore, Md. 21218 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Va Cem 02-14-97 Owings Mills | | Date | | 20c. Location - City or Town, State
Md. | |
| | 21. Signature of Funeral Service Licensee
<i>Deloris M. Holmes</i> | | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. CIRRHOSIS OF LIVER ACUTE NARCOTIC INTOXICATION
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CIRRHOSIS OF THE LIVER | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
found 2-9-97 | | 28b. Time of Injury
found 11:15 AM | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
RESIDENCE | | | | 28d. Describe how injury occurred
UNKNOWN | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3805 DELVERNE RD. BALTIMORE MARYLAND | | | | | | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
<i>Therese M. Shull MD</i> | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
FEB. 10, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Marydawn P. Kowal 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | 32. Registrar's Signature
<i>Marydawn P. Kowal</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04134

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Reize Herche

2. Date of Death

Month
Feb.

Day

12,

Year

1997

3. Time of Death

6:15 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6281 Davis Rd.

4b. City, Town, or Location of Death

Woodbine

4c. County of Death

Carroll

5. Social Security Number

215-16-7881

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept. 12, 1997

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Woodbine

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6281 Davis Rd.

10f. Zip Code

21749

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Charles A. Herche

18. Mother's Name (First, Middle, Maiden Surname)

Catherine M. Schlicker

19a. Informant's Name/Relationship (Type, Print)

Arthur R. Herche (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6281 Davis Rd. Woodbine, MD 21749

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lake View Memorial Park Feb. 15, 1997 Sykesville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burrier-Queen Funeral Directors
1212 W. Old Liberty Rd.
Winfield, MD 2178423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

10 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, pneumonia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven G. Miller, MD 1247 Liberty Rd Edersburg MD 21784

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04135

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor Hatcherson

2. Date of Death

February 11 1997

Day Year

3. Time of Death

2:30 A.M.

4e. Facility Name (If not Institution, give street and number)

413 - 5th Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

220 14 0125

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 25, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

413 - 5th Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Robert Elliott

18. Mother's Name (First, Middle, Maiden Surname)

Fredericka Bohlman

19a. Informant's Name/Relationship (Type, Print)

Joyce Heid / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

693 Willowby Run Pasadena, Maryland 21122

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery

Date

2/14/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Richard Gonce

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Endometrial Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

8 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wm C Waterfield M.O.

29c. License number

024356 MO

29d. Date signed (Month, Day, Year)

Feb 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wm C Waterfield M.O.

900 Caton Ave

Balt Md 21229

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04136

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice Hawkins

2. Date of Death

Month Day Year
FEBRUARY 10, 1997

3. Time of Death

8:42 P.M.

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

NA

Funeral
Director

5. Social Security Number

212-34-0945

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
05-17-35

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

713 N. Madeira Street

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
11th Grade

NA College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

School System

17. Father's Name (First, Middle, Last)

Joe Jones

18. Mother's Name (First, Middle, Maiden Surname)

Ruby Trogon

19a. Informant's Name/Relationship (Type, Print)

James Hawkins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3113 Shannon Drive Baltimore, Md. 21213

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

02-14-97

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Anoxic brain injury

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Acute myocardial infarction

Due to (or as a consequence of):

1 day

c. Coronary artery disease

Due to (or as a consequence of):

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24e. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee M Krug MD 110 Tower Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

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Department of Health and Mental Hygiene.
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/Medical
Examiner

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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

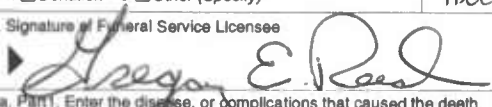
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04137

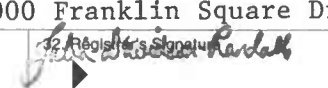
Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------------|--|--|--|---|---|--|---|----|---------------------------|--------|----|----------------------|----------|----|--|--|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Gene Bostic HUEY | | | | 2. Date of Death
Month Day Year
February 10, 1997 | | 3. Time of Death
2:55 P.M. | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rossville | | 4c. County of Death
Baltimore | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
216-20-6259 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 23, 1927 | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | | | | | | | | | | | | | | |
| Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| 10a. State
Maryland | | | 10b. County
Baltimore | | | 10c. City, Town or Location
Dundalk | | | | | | | | | | | | | | | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 10e. Street and Number
744 Aldworth Road | | | 10f. Zip Code
21222 | | | | | | | | | | | | | | | |
| 10g. Citizen of What Country?
United States | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | | | | | | | | | | | | | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | 15. Decedent's Education (Specify only highest grade completed)
12 Years | | | | | | | | | | | | | | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Foreman | | | 16b. Kind of Business/Industry
Steel Industry | | | 17. Father's Name (First, Middle, Last)
Samuel B. Huey | | | | | | | | | | | | | | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Lela G. Meekins | | | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Karen McKay/Grand Daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25 Freedom Ct. Baltimore, Maryland 21220 | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. | | | 20c. Location - City or Town, State
2/13/97 Towson, Maryland | | | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 | | | | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Esophageal varices</td> <td>6 days</td> </tr> <tr> <td>b.</td> <td>Liver failure</td> <td>15 years</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Esophageal varices | 6 days | b. | Liver failure | 15 years | c. | | | d. | | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Esophageal varices | 6 days | | | | | | | | | | | | | | | | | | |
| | b. | Liver failure | 15 years | | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | |
| Renal failure | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | | | | | | | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | | | | | | | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how Injury occurred | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | | | | | | | | | | | | | | | | |
| 29c. License number
R D 1930 | | | | | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
2/10/1997 | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. James Orford 9000 Franklin Square Dr. Baltimore, Maryland 21237 | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04 138

ITEM26 per DR.G-744 2-13-97 eoh

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|--|--------------------------|---|--|--|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Pauline Howard | | | 2. Date of Death
Month 02 Day 03 Year 97 | | | 3. Time of Death
10:27 AM | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
5952 Daywalt Avenue Apt. "K" | | | 4b. City, Town, or Location of Death
Baltimore | | | 4c. County of Death
NA | | | | | |
| Funeral
Director | 5. Social Security Number
219-38-4463 | | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
56 Yrs. | | 8. Date of Birth (Month, Day, Year)
12-28-40 | | 9. Birthplace (State or Foreign Country)
NC | | |
| | Usual Residence of Decedent | | | | | | | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Na | | 10c. City, Town or Location
Baltimore | | | | | | | |
| | 10e. Street and Number
5952 Daywalt Avenue Apt. "K" | | | | 10f. Zip Code
21206 | | | 10g. Citizen of What Country?
USA | | | | |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th Grade
College (1-4 or 5+) Na | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cook | | | 16b. Kind of Business/Industry
in and out of home | | | | | |
| To Be Completed by Funeral Director | 17. Father's Name (First, Middle, Last)
Theodore Nixon | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Naomi Alexander | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Robert Howard | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5952 Daywalt Avenue Baltimore, MD. 21206 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cem. | | | Data
02-05-97 | | 20c. Location - City or Town, State
Baltimore, Md. | | | |
| | 21. Signature of Funeral Service Licensee
<i>Synette K. Jones</i> | | | 22. Name and Address of Facility
Baltimore, Maryland
WM.C. March FH 1101 E. North Avenue 21202 | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
e. Metastatic Lung Cancer
Due to (or as a consequence of): | | | | | | | | | | Approximate Interval Between Onset and Death
18 mos | |
| | 23b. Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> SPCA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
<i>William B. Jackson II MD</i> | | | 29c. License number
D45039 | | | 29d. Date signed (Month, Day, Year)
2/4/97 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William B. Jackson II MD 9105 Franklin Square Dr. Baltimore MD 21037 | | | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04139

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edna May Hullihen

2. Date of Death
Month Day Year

FEB. 8, 1997

3. Time of Death

10:05 PM

4e. Facility Name (If not institution, give street and number)

St. Elizabeth's Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-24-3921

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC. 7, 1904

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1134 Gloria Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edwin S. Delsite

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Catherine Deal

19e. Informant's Name/Relationship (Type, Print)

John Roger Hullihen, Jr. - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1134 Gloria Ave., Balto., Md. 21227

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

2/12/97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge
7250 Washington Blvd., Elkridge, Md. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aortic Aneurysm

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dissecting aortic aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D34951

29d. Date signed (Month, Day, Year)

2 10 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Edmund P. Skovnik 455 Federal Avenue 100 Baltimore MD 21228

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.


Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

F


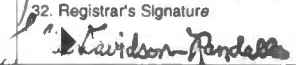
| | | | | | | | | | |
|---|---|---------------------------------------|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PRECIOUS AMBER HAMBRICK | | | | 2. Date of Death
Month FEBRUARY Day 6 , Year 1997 | | 3. Time of Death
1:15 P.M. | | |
| | 4a. Facility Name (If not institution, give street and number)
107 BROOKBERRY DRIVE APT. 1C | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | | |
| Funeral
Director | 5. Social Security Number
216 47 5618 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs 07 Months 13 | 8. Date of Birth (Month, Day, Year)
JUNE 19, 1996 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | |
| 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
RANDALLSTOWN | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
3418 BARRY PAUL CT. APT. 103 | | | | 10f. Zip Code
21133 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 0 Collage (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
INFANT | | 16b. Kind of Business/Industry
N/A | | | |
| 17. Father's Name (First, Middle, Last)
CHARLES A.W. HAMBRICK | | | | 18. Mother's Name (First, Middle, Maiden Summa)
HOPE BARRETT | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
HOPE HAMBRICK (MOTHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 3418 BARRY PAUL CT. APT 103 RANDALLSTOWN, MD | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOUNT ZION CEM | | Date
2/12/97 | | 20c. Location - City or Town, State
LANSLOWNE, MD. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
CAPLE FUNERAL SERVICE 5502 WINNER AVENUE BALTIMORE, MD 21215 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SUDDEN INFANT DEATH SYNDROME
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
FEBRUARY 7, 1997 | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
THEODOR M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04141

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM C HILL

2. Date of Death

February 16, 1997

3. Time of Death

3:02 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

Funeral
Director

5. Social Security Number

220-38-9675

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-28-41

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1102 Mosher Street

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Never Worked

16b. Kind of Business/Industry

Disabled

17. Father's Name (First, Middle, Last)

Lorenzo Hill

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Hill

19a. Informant's Name/Relationship (Type, Print)

Roberta Purvis - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1104 N. Dukeland Street, Baltimore, MD. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

2-15-97 Glen Burnie, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Albert P. Wylicz HHPA Baltimore, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dilated cardiomyopathy

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AIDS

Chronic renal insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D50214

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jerome Kim, MD 16 S. Eutaw St., Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04142

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bernard Harrison, Jr.

2. Date of Death
Month Day Year

February 11, 1997

3. Time of Death
6:30 AM

4a. Facility Name (If not institution, give street and number)

2126 Braddish Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

212-48-6244

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year
Months Days

If Under 24 Hrs.
Hours Min.

8. Date of Birth
(Month, Day, Year)

Dec 18, 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2126 Braddish Avenue

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

High School

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Construction Laborer

16b. Kind of Business/Industry

Dan Brothers

17. Father's Name (First, Middle, Last)

Bernard Harrison, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Coleman

19a. Informant's Name/Relationship (Type, Print)

father

Bernard Harrison, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2126 Braddish Avenue Baltimore, Maryland 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD Veteran Cem/Garrison

Date

Feb 18

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

Ernest J. Perry Jr.

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls Parkway
Baltimore, Maryland 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

Metastatic rhabdomyosarcoma

Approximate
Interval Between
Onset and Death

3 year

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Sohyang M.D. M.D.

29c. License number

PO 9828

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SO HYANG PARK, Baltimore VA Hospital, Baltimore, MD. 21201

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04143

Items: 10c,e,f,19b per F.H. G-744 2/13/97 ^{re} Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>WARREN JACKSON</i> | | | | 2. Date of Death
Month <i>FEB</i> Day <i>10</i> Year <i>97</i> | | 3. Time of Death
<i>12 55 AM</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Manor Care Towson</i> | | | | 4b. City, Town, or Location of Death
<i>Towson</i> | | 4c. County of Death
<i>Baltimore</i> | | |
| Funeral
Director | 5. Social Security Number
<i>212-22-7563</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Nov. 2, 1920</i> | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | |
| | 10a. State
<i>Maryland</i> | | 10b. County
<i>Baltimore</i> | | 10c. City, Town or Location
<i>Cockeysville TOWSON</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10e. Street and Number
<i>8 H Hogarth Circle</i> | | | | 10f. Zip Code
<i>21286</i> | | 10g. Citizen of What Country?
<i>USA</i> | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <i>WWII</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>7th grade</i> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>TRUCK DRIVER</i> | | 16b. Kind of Business/Industry
<i>Baltimore County Dept of Education</i> | | | | |
| | 17. Father's Name (First, Middle, Last)
<i>STANLEY JACKSON</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Lillian Larkins</i> | | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>BERTHA JACKSON, Wife</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>605 GOUCHER BLVD. TOWSON 21286</i>
<i>8 H Hogarth Circle Cockeysville, Maryland</i> | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Maryland National Memorial</i> | | Date
<i>2/12/97</i> | | 20c. Location - City or Town, State
<i>LAUREL, Maryland</i> | | |
| | 21. Signature of Funeral Service Licensee
<i>Gray Harris</i> | | | | 22. Name and Address of Facility
<i>CHARTMAN - HARRIS Funeral Home</i>
<i>5540 REISTERSTOWN ROAD</i>
<i>Baltimore, Maryland 21215</i> | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death) | | | | Approximate Interval Between Onset and Death | | | | |
| | a. <i>Progressive Neurologic Disorder</i>
Due to (or as a consequence of): | | | | <i>1 YR</i> | | | | |
| | b. <i>Cerebral Thrombosis</i>
Due to (or as a consequence of): | | | | <i>1 XR</i> | | | | |
| | c. <i>Cerebrovascular Disease</i>
Due to (or as a consequence of): | | | | <i>1 XR</i> | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Insulin Dependent Diabetes mellitus</i> | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Walter R. Welzant MD</i> | | 29c. License number
<i>D12039</i> | | 29d. Date signed (Month, Day, Year)
<i>FEB 10, 1997</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Walter R. Welzant MD, 100 Osler Dr., Ste. 107, Towson, MD 21204</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>FEB 13 1997</i> | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04144

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marguerite Mary Kane | | | | 2. Date of Death
Month Day Year
February 12 1997 | | | | 3. Time of Death
4:35 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
217-40-0776 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
55 Yrs. | | 8. Date of Birth (Month, Day, Year)
January 6, 1942 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
3507 Parklawn Avenue | | 10f. Zip Code
21213 | | 10g. Citizen of What Country?
United States | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | College (1-4 or 5+)
5+ | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Teacher | | | | 16b. Kind of Business/Industry
Baltimore City Public Schools | |
| | 17. Father's Name (First, Middle, Last)
L. George Kane | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Valerie Mazur | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mr. George T. Kane / Brother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 Stony Meadow Court Lutherville, MD 21093 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith Cemetery | | Date
2/15/97 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
Malcolm Knight | | | | 22. Name and Address of Facility
Leonard J. Ruck, Inc. 5305 Harford Road
Baltimore, MD 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Ovarian Cancer
Due to (or as a consequence of):
2 1/2 years
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. Signature and title of certifier
Kendall Faulkner
29c. License number
D25643
29d. Date signed (Month, Day, Year)
2/12/97 | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Kendall Faulkner, M.D. 2300 Dulany Valley Road, Towson, MD 21204 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997
32. Registrar's Signature
John H. Ruck | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04145

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Annette Landsman

2. Date of Death

Feb. 10th 1997

3. Time of Death

9:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Levindale Hebrew Geriatric Ctr

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-07-5114

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03-21-19

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3031 Fallstaff Rd #103

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white.

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER/OPERATOR

16b. Kind of Business/Industry

SHOES

17. Father's Name (First, Middle, Last)

JACK

RUDOLPH

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE

CHASEN

19a. Informant's Name/Relationship (Type, Print)

HARRY LANDSMAN (HUS.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3031 FALLSTAFF RD., APT. 103 BALTO., MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MIKRO KODESH BETH ISRAEL 2/12/97

Date

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive heart failure

≈ 6 months

Due to (or as a consequence of):

b.

Arteriosclerotic heart disease

> 1 year

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral vascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] physician

29c. License number

D44817

29d. Date signed (Month, Day, Year)

Feb. 10th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Rajani 2434 W Belvedere Ave, Baltimore

31. Date filed (Month, Day, Year)

FEB 13 1997

Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04146

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles J. Miller

2. Date of Death

February 11, 1997 00:52 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

County of Death

N/A

5. Social Security Number

213-28-2385

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

October 9, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll Co.

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5782 Victor Drive

10f. Zip Code

21784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

George W. Miller

18. Mother's Name (First, Middle, Maiden Surname)

Mae E. Zavodny

19a. Informant's Name/Relationship (Type, Print)

Mrs. Dolores G. Miller/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5782 Victor Drive Eldersburg, Maryland 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lake View Memorial Park

Date

2/14/97

20c. Location - City or Town, State

Sykesville, Maryland

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 2121423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Acute dissection*
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death*Chrs*Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. *Coronary artery disease*
Due to (or as a consequence of):*10 years*c. *Atherosclerotic disease*
Due to (or as a consequence of):*10 years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office,
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Phil Buescher MD

29c. License number

MD 5895

29d. Date signed (Month, Day, Year)

Feb 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phil Buescher MD Union Memorial Hospital

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

*John Davidson-Randall*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Report of the
Committee on
the State of
the Union

1877-1878

Printed by
the Government
Printer, Washington, D.C.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

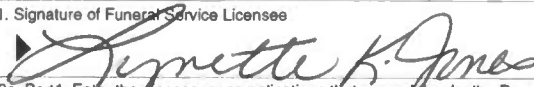
Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

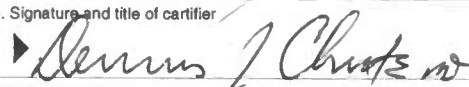
| | | | | | |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
WAYNE | | 2. Date of Death
Month FEBRUARY Day 08 Year 1997 | | 3. Time of Death
0645AM | |
| 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL E.R. | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
NA | |
| 5. Social Security Number
212-62-6642 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
39 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
02-21-57 |
| 9. Birthplace (State or Foreign Country)
Md. | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Md. | 10b. County
NA | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
4829 Gilray Drive | | 10f. Zip Code
21214 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th Grade
College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Unemployed | | 16b. Kind of Business/Industry
Laborer | |
| 17. Father's Name (First, Middle, Last)
Franklin L. Medley | | 18. Mother's Name (First, Middle, Maiden Summa)
Edith Logan | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Edith Medley | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4829 Gilray Drive Baltimore, Maryland 21214 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cem. 02-12-97 | | 20c. Location - City or Town, State
Baltimore, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
ACUTE ETHANOL, COCAINE AND NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
{
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
found 2/8/97 | | 28b. Time of Injury
found at 6:00 A.M. | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
unknown | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
found at home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4829 Gilray Drive Baltimore, Maryland | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | |
| | | 29d. Date signed (Month, Day, Year)
FEBRUARY 08, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
 | | | |

State
Registrar

97 04148

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>William Montgomery</i> | | | | 2. DATE OF DEATH
MONTH <i>Feb</i> DAY <i>8</i> YEAR <i>1997</i> | | | | 3. TIME OF DEATH
<i>6:12am</i> M | | | | | |
| 4. SOCIAL SECURITY NUMBER
<i>705-12-7619</i> | | | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>79</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>02-15-17</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>SC</i> | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Bayview</i> | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore</i> | | | | 9c. COUNTY OF DEATH
<i>Na</i> | | | |
| 10a. STATE
<i>Md</i> | | | | | | 10b. COUNTY
<i>NA</i> | | 10c. CITY, TOWN OR LOCATION
<i>Baltimore</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>5009 Frankford Avenue</i> | | | | | | 10f. ZIP CODE
<i>21206</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>Black</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) <i>8th Grade</i>
College (1-4 or 5+) <i>NA</i> | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Constrution Worker</i> | | | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Kerby Contracting Co.</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Issacc Montgomery</i> | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Maggie Hunter</i> | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Alice Lee</i> | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>5409 Remmell Avenue Baltimore, Md. 21206</i> | | | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Garrison Forest VA Cem. 02-14-97 Owings Mills</i> | | | | 20c. LOCATION — City or Town, State
<i>Md.</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Salvatore Mahoney</i> | | | | | | 22. NAME AND ADDRESS OF FACILITY
<i>WM.C. March FH 1101 E. North Avenue</i> | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i> | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| <i>Coronary artery disease</i> | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>stroke</i>
<i>respiratory failure</i> | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY
(Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Gary Kaye MD</i> | | | | | | 29c. LICENSE NUMBER
<i>D41617</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>Feb 8, 1997</i> | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Gary Kaye 10805 Karkov Ridge Rd Columbia 21044</i> | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 13 1997</i> | | | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

97 04149

ITEM: 10bce, 14 per FH G_744 eoh

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Dr. Rudolph</i> | | | | 2. DATE OF DEATH
MONTH <i>Feb</i> DAY <i>8th</i> YEAR <i>1997</i> | | | | 3. TIME OF DEATH
<i>1230 PM</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>220-20-7516</i> | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
<i>98</i> YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
<i>April 20 1898</i> | | 8. BIRTHPLACE (State or Foreign Country)
<i>New York</i> | |
| 9a. FACILITY NAME (If not institution, give street and number)
<i>Genesis Long Green</i> | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Baltimore City</i> | | | | 9c. COUNTY OF DEATH
<i>Baltimore City</i> | |
| 10a. STATE
<i>Md</i> | | 10b. COUNTY
<i>BALTIMORE</i> | | 10c. CITY, TOWN OR LOCATION
<i>Baltimore City</i> PARKVILLE | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
<i>2310 CIDER MILL RD</i> | | | | 10f. ZIP CODE
<i>21234</i> | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>WHITE</i> | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>5+</i> | | 16a. OCCUPATION'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
<i>Professor of Chemistry</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Chemical Industry</i> | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>HARRY MACY</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>ROSE FEDER</i> | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>MRS. GLADYS VOCCI (FRIEND)</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>2310 CIDER MILL ROAD PARKVILLE, MD (21234)</i> | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>MONTEFIORE</i> | | 20c. LOCATION — City or Town, State
<i>2-11-97 SPRINGFIELD GARDENS, N.Y.</i> | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Scott M. Gottle</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>SOL LEVINSON & BROS., INC.
8900 Reisterstown Road Pikesville, MD 21208</i> | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Congestive Heart Failure</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>b. Ischemic Cardiac Disease</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>c.</i>
DUE TO (OR AS A CONSEQUENCE OF):
<i>d.</i>

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death
<i>2 weeks</i>
<i>yrs</i> | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Organic Dementia of Alzheimer type</i>
<i>Recent Pneumonia & Urrosyris</i> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| | | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Joseph III M.D.</i> | | | | | | 29c. LICENSE NUMBER
<i>D-22334</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>Feb 8th 1997</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>Joseph III M.D. 3825 Greenspring Avenue / Chubb's Corp</i> | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>FEB 13 1997</i> | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04150

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN

MARKO

2. Date of Death
Month Day Year
FEBRUARY 10, 19973. Time of Death
09:31PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

169-07-4572

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 25, 1918

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

PA

10b. County

Somerset

10c. City, Town or Location

Central City

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

414 Ash Street

10f. Zip Code

15926

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Coal Miner

16b. Kind of Business/Industry

Mining

17. Father's Name (First, Middle, Last)

Andrew Marko

18. Mother's Name (First, Middle, Maiden Surname)

Mary Halub

19a. Informant's Name/Relationship (Type, Print)

Theresa Chononski, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2104 Bay Drive, Annapolis, MD 21401

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John the Baptist Cemetery

Date

2/14/97

20c. Location - City or Town, State

Central City, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Homes, Inc.
7250 Washington Blvd., Elkridge, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. coronary artery disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute renal failure

peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ NoHospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter J. Gruber MD, PLD, Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04151

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Irene T. NIXON

2. Date of Death

February 12, 1997

3. Time of Death

3:00 A.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-38-7139

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 28, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 Wolf Trap Ct.

10f. Zip Code

21236

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

real estate agent

16b. Kind of Business/Industry

real estate agency

17. Father's Name (First, Middle, Last)

Philip Boniface Smith

18. Mother's Name (First, Middle, Maiden Surname)

Irene Kearny

19e. Informant's Name/Relationship (Type, Print)

Theresa M. Travers/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

903E Woodbridge Ct. Edgewood, MD 21040

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cemet. 2/14/97 Baltimore, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John D. Mitchell IV

22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc.
6500 York Rd.
Baltimore, MD 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Gastrointestinal Bleeding

7 hours

Due to (or as a consequence of):

b. Alcoholic Liver Disease

1 day

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Encephalopathy, Diabetes Mellitus

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aileen S. Garcia-Gayoso

29c. License number

RD 1906

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Aileen S. Garcia-Gayoso 9000 Franklin Square Drive Baltimore, Md. 21237

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

John D. Mitchell IV

State
Registrar

Baltimore, Maryland 21215-0020

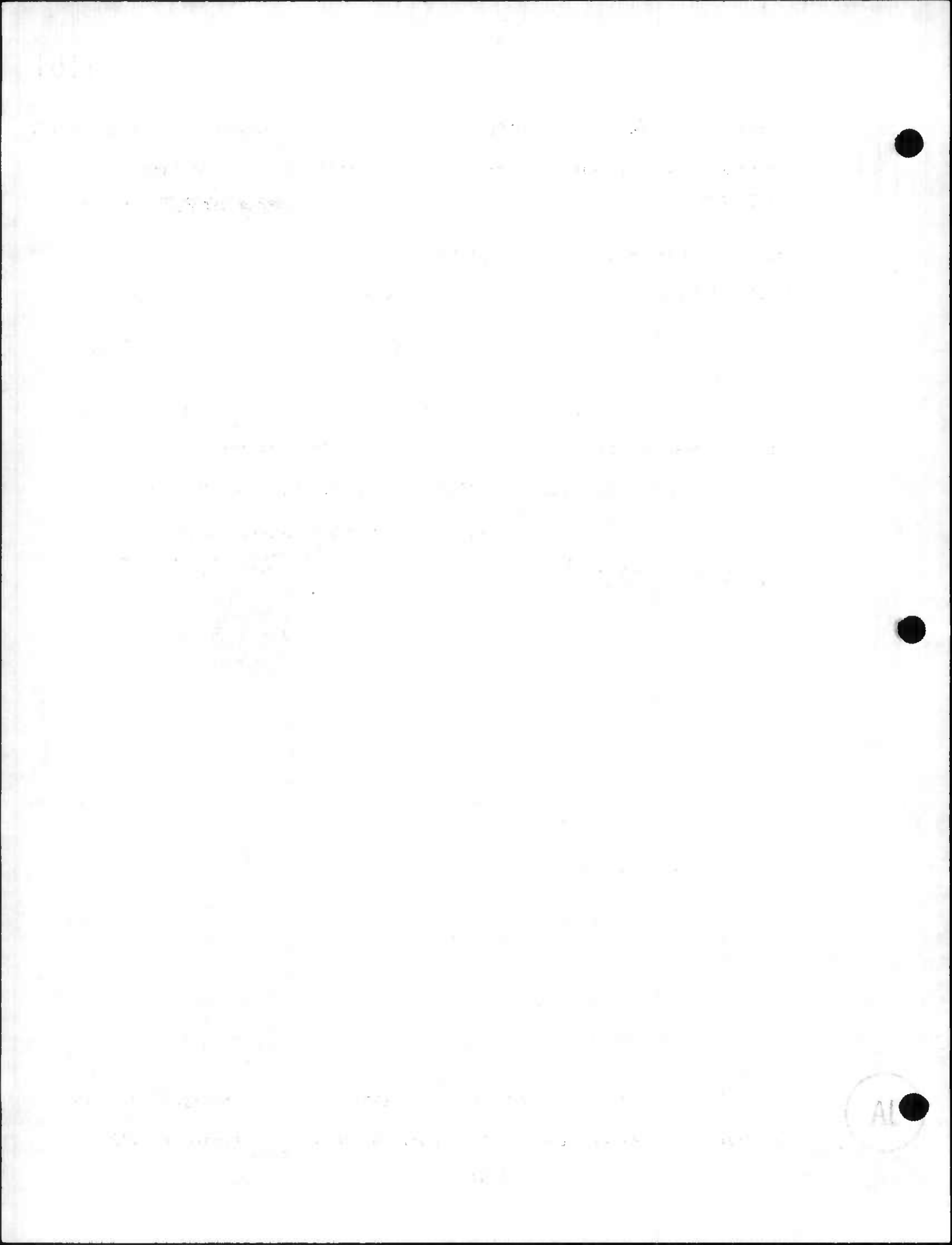
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04152

| | | | | | | | | |
|---|---|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Helen Nussear | | | | 2. Date of Death
Month February Day 8 Year 1997 | | 3. Time of Death
7:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Charlottesville Care Center | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
213-56-5943 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
95 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 30, 1901 | |
| | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | |
| To Be Completed by
Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
711 Maiden Choice Lane | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 year | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
Thomas Kelly | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Childs | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Nancy Farmer (daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
343 Tunbridge Road Baltimore, Maryland 21212 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gettysburg National Cemetery | | 20c. Location - City or Town, State
2-12-97 Gettysburg, Pennsylvania | | | |
| | 21. Signature of Funeral Service Licensee
George Ferman | | 22. Name and Address of Facility
Mitchell-Wiedefeld Home
6500 York Road Baltimore, Maryland 21212 | | | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Gastrointestinal bleed
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
f. weeks
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Andrew Latis | | | | 29c. License number
1347447 | | 29d. Date signed (Month, Day, Year)
February 9, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Latis 711 Maiden Choice Lane, Catonsville, Maryland | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
J. A. Anderson | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04153

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
MELVIN G. NAZARENUS | | | | 2. Date of Death
Month FEBRUARY Day 10 Year 1997 | | 3. Time of Death
10:28pm | |
| 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL Hospital Assn | | | | 4b. City, Town, or Location of Death
Glen Burnie | | 4c. County of Death
ANNE ARUNDEL | |
| 5. Social Security Number
212 07 9933 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 17, 1917 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Pasadena | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1414 Woodland Beach Road | | 10f. Zip Code
21122 | | 10g. Citizen of What Country?
U.S. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: W.W. II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanic | | 16b. Kind of Business/Industry
Automotive | | 17. Father's Name (First, Middle, Last)
Pete Nazarenus | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Mary Mueller | | 19a. Informant's Name/Relationship (Type, Print)
Melvin Nazarenus / son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8364 Hilda Drive Pasadena, Maryland 21122 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery | | 20c. Date
2/13/97 | | 20d. Location - City or Town, State
Baltimore, Maryland | | 21. Signature of Funeral Service Licensee
George J. Gonce | |
| 22. Name and Address of Facility
Gonce Funeral Home P.A.
4001 Ritchie Highway Baltimore, Md. 21225 | | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. DIABETES MELLITIS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | Approximate interval Between Onset and Death
1 HOUR
5 YEARS | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Piece of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day Year)
28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Dr. H. Schreider MD | |
| 29c. License number
D28221 | | 29d. Date signed (Month, Day, Year)
February 10, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAN H. SCHREIDER MD 3011 HOSPITAL DRIVE GLEN BURNIE MARYLAND | | 31. Date filed (Month, Day, Year)
FEB 13 1997 | |
| 32. Registrar's Signature
John Davidson | | 33. Registrar's Title
21061 | | 34. Registrar's Name
21061 | | 35. Registrar's Address
21061 | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 04154

Certificate of Death

Reg. No.

| | | | | | | | | |
|-------------------------------------|---|--|---|--------------------------------|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last) Rose OWENS | | | | 2. Date of Death (Month, Day, Year) JUN 29 97 | | 3. Time of Death 9:56 PM | |
| | 4a. Facility Name (If not institution, give street and number) LEVINDALE NURSING HOME | | | | 4b. City, Town, or Location of Death BALTIMORE | | 4c. County of Death - | |
| Funeral
Director | 5. Social Security Number
219-76-0585 | 8. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
81 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Oct 18, 1915 | | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
HOWARD | 10c. City, Town or Location
JESSUP | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
7381 MONTEVIDEO RD | | | 10f. Zip Code
20794 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) - College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NEVER WORKED | | | 16b. Kind of Business/Industry
- | | |
| | 17. Father's Name (First, Middle, Last)
William OWENS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSE BUSH | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JOSEPH OWENS / BROTHER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7381 MONTEVIDEO RD JESSUP MD 20794 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATORY | | Date
2/1/97 | | 20c. Location - City or Town, State
BELTSVILLE, MD | |
| | 21. Signature of Funeral Service Licensee
Rudolph J. 35th | | | | 22. Name and Address of Facility
GARY L. KAUFMAN FUNERAL HOME
7250 WASHINGTON BLVD ELKIDGE, MD 21227 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA
Due to (or as a consequence of):
b. MENTAL RETARDATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.
Due to (or as a consequence of): | | | | | | | |
| | Approximate Interval Between Onset and Death
WKS
YRS | | | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
NA
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
M. Monahan MD | | | | 29c. License number
D45757 | | 29d. Date signed (Month, Day, Year)
JAN 30, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATTIAS MONAHAN 2434 W. Belvedere Balt, MD | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | 32. Registrar's Signature
J. J. [Signature] | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04155

ITEM: 1 per DR.G-744 2-13-97 eoh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM L. PERRYMAN, Sr.

2. Date of Death

Month Day Year
FEBRUARY 9, 1997

3. Time of Death

1208 Hrs

4a. Facility Name (If not Institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

217-22-0331

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
July 12, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8042 Liberty Road

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Baltimore County

17. Father's Name (First, Middle, Last)

Lynwood Perryman

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Perryman

19a. Informant's Name/Relationship (Type, Print)

William L. Perryman, Jr (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7331 Jennifer Way, Sykesville, Md 21784

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

2/13/97

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a. Due to (or as a consequence of):

PNEUMONIA

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 DAY

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GANGRENE (R) FOOT, COPD

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. Navi MD

29c. License number

D37333

29d. Date signed (Month, Day, Year)

FEBRUARY 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. NAVI MD, MHC, BALTO. MD 21133

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

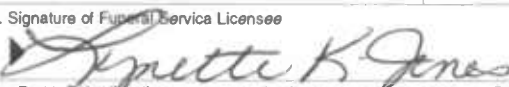
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04 156

Certificate of Death

Reg. No.


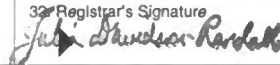
| | | | | | | | |
|--|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Zebbie D. Pipkin | | | 2. Date of Death
Month 02 Day 08 Year 97 | | 3. Time of Death
11:10pm | |
| | 4a. Facility Name (If not institution, give street and number)
LongGreen Center-Gensis Elder Care | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Na | |
| Funeral
Director | 5. Social Security Number
216-10-4777 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
10-01-12 |
| | 9. Birthplace (State or Foreign Country)
NC | | | | | | |
| To Be Completed by
Funeral Director | 10a. State
Md | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
4800 Wrenwood Avenue | | | 10f. Zip Code
21212 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th Grade
College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Bethlehem Steel Corp. | | 16b. Kind of Business/Industry
Steelside | | |
| | 17. Father's Name (First, Middle, Last)
Lawrence W. Pipkin | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ima McCullough | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Elizabeth Pipkin | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4800 Wrenwood Avenue Baltimore, Md. 21212 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. Cem 02-13-97 | | 20c. Location - City or Town, State
Randallstown, Md. | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Myocarditis or infarction
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) as stated. | | | | | | |
| | 29b. Signature and title of certifier
 Attending | | 29c. License number
D17118 | | 29d. Date signed (Month, Day, Year)
2/10/97 | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Schwartz M.D. 4000 Old Court Rd Suite 203 .21208 | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04157

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Oliver Party

2. Date of Death

February 9, 1997

3. Time of Death

11:42PM

4a. Facility Name (If not institution, give street and number)

3113 Grace Road

4b. City, Town, or Location of Death

Edgemere

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-24-9957

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 8, 1927

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3113 Grace Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Years

18e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tractor Repair

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Lucien E. Party

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Leer Paulk

19a. Informant's Name/Relationship (Type, Print)

Eupha Party/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3113 Grace Road Edgemere, Maryland 21219

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Crest Lawn Cemetery 2/12/1997

Date

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Cancer lung

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18487

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYO THANT 6830 HOSPITAL DRIVE, STE 206 BALTO, MD 21237

State
Registrar

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04158

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JENNY

ROBERTS

2. Date of Death

FEBRUARY 11, 1997 4:50PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND BALTIMORE

4c. County of Death

5. Social Security Number

212-30-2541

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 5, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

148 Brandon Road

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Home Health Aide

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

George Earl Roberts

18. Mother's Name (First, Middle, Maiden Surname)

June Barbara Light

19a. Informant's Name/Relationship (Type, Print)

B. Anne Maxfield

DTR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

148 Brandon Road Baltimore, Maryland 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Cemetery

Date

2/13/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Wiedefeld Home
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CEREBROVASCULAR ACCIDENT

Approximate Interval Between Onset and Death

3 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

02-11-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS KHOO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04159

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Rozmarynowski

2. Date of Death

Month

Day

Year

Feb.

08

1997

0450

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213 01 9523

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 10, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Crownsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

265 Long Point Road

10f. Zip Code

21032

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Constantine Sokolis

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Laskowska

19a. Informant's Name/Relationship (Type, Print)

Mary Rozmarynowski / in law Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

265 Long Point Road Crownsville, Maryland 21032

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Rosary Cemetery

Date

2/11/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jerome J. Jankowski

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. I Schemic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5-10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. J. Gamel MD

29c. License number

D506071

29d. Date signed (Month, Day, Year)

Feb. 08 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter Gamel, St. Agnes Hospital

31. Date filed (Month, Day, Year)

FEB 13 1997

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 04160

Certificate of Death

Reg. No.

| | | | | | |
|--|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
James RANDALL | | 2. Date of Death
Month February 9, 1997 Year | | 3. Time of Death
10:00 am |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
214-50-3601 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
48 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
06-16-48 | | 9. Birthplace (State or Foreign Country)
Md. | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Md. | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
4831 Aberdeen Avenue | | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
USA |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12th Grade | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supervisor | | 16b. Kind of Business/Industry
N.S.A. |
| 17. Father's Name (First, Middle, Last)
Lyndia Randall | | | 18. Mother's Name (First, Middle, Maiden Summa)
Marie Norris | | |
| 19a. Informant's Name/Relationship (Type, Print)
Berta Randall-Mitchell | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4831 Aberdeen Avenue Baltimore, Maryland 21206 | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. Cem. | | 20c. Location - City or Town, State
02-13-97 Randallstown, Md. | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Urosepsis and aspiration pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | |
| Approximate interval between Onset and Death
24 hours | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cardiac Arrest, Anoxic encephalopathy | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
RD2121 | | 29d. Date signed (Month, Day, Year)
February 10, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Carol Lee M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04161

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Theodore

Robinson

2. Date of Death

Month

Day

Year

2

6

1997

3. Time of Death

10:45 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Greenspring Nursing & Rehab. Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-16-9551

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

10-17-22

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4615 Park Heights Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Packer

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

James Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Cunells

19a. Informant's Name/Relationship (Type, Print)

Portia Cephas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1631 W. Mulberry St. Balto., MD 21223

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD Veteran Cemetery

Date

2-11-97

20c. Location - City or Town, State

Owings, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Inland Church Funeral Home
1712 W. North Ave., Baltimore, MD 2121923a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ACUTE RESPIRATORY FAILURE

DAY

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

YEARS

Due to (or as a consequence of):

c. ARTERIOSCLEROTIC HEART DISEASE

YEARS

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OLD CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicidal 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D13664

29d. Date signed (Month, Day, Year)

2/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B.C. VENERACION JIMENEZ 76 MERRITT BLVD, BALTO, MD 21222

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04162

ITEM:10b,20b per FH G-744 2-13-97 eoh

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL C RUBIN

2. Date of Death

February 10 1997

3. Time of Death

8:20pm

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

088-28-9137

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 24, 1932

9. Birthplace (State or Foreign Country)

BELGIUM

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3411 FALLSTAFF ROAD

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ACTUARY

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

JOSHUA

CENSOR

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER

SCHOR

19a. Informant's Name/Relationship (Type, Print)

ALFRED RUBIN / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3411 FALLSTAFF ROAD BALTIMORE, MD 21215

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)HAMENUCHOT
HAR HAMENUCHOP

Date

2/11/97

20c. Location - City or Town, State

JERUSALEM, ISRAEL

21. Signature of Funeral Service Licensee

Joel J. Lewis

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

Anasarca

Quadriplegia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
reliable prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Signature and title of certifier

Michael Zang, M.D.

29c. License number

AS2402321429023

29d. Date signed (Month, Day, Year)

February 10 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ZANG, M.D. SINAI HOSPITAL OF BALTIMORE

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

Richard P. Kelle

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04163

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Katherine Sompayrac

2. Date of Death

February 9, 1997

3. Time of Death

10:15 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Meridian Long Green Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-52-1535

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 29, 1904

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

224C Rodgers Forge Rd.

10f. Zip Code

21212

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Oscar Henderson

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Wolford

19a. Informant's Name/Relationship (Type, Print)

Alan H. Stocksdales/Power of Att. 6717 Harford Rd. Baltimore, MD 21234

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

2/12/97

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

John D. Mitchell

22. Name and Address of Facility

Mitchell-Wiedefeld Home, Inc.
6500 York Rd.
Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ALZHEIMER'S DISEASE

Approximate Interval Between Onset and Death

YEARS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

N/A

28b. Time of Injury

N/A

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John D. Mitchell

29c. License number

D34952

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5444 Belair Road Baltimore MARYLAND 21206

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

John D. Mitchell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

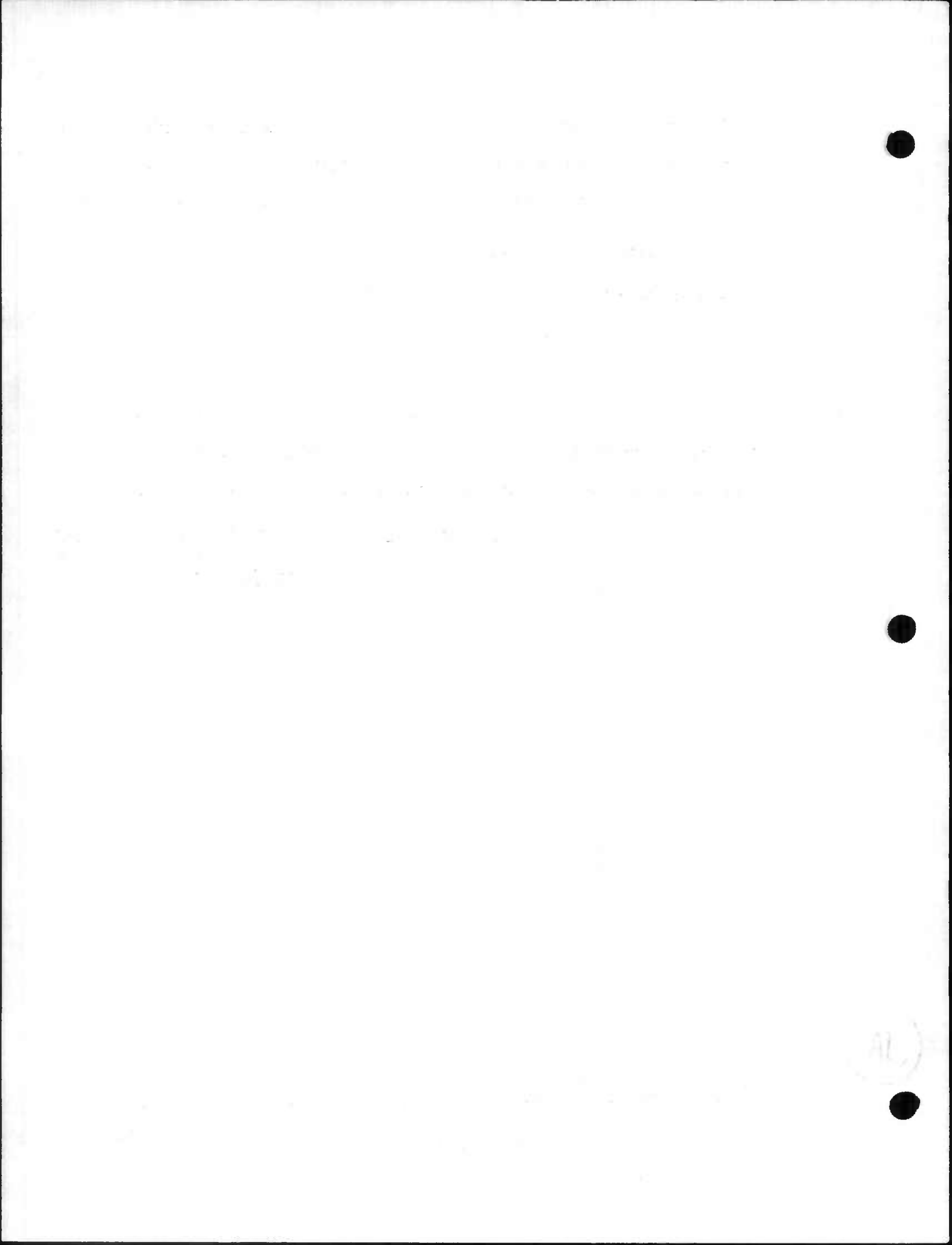
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04164

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY FRANKLIN SEHER

2. Date of Death
Month Day Year

FEBRUARY 10, 1997 9:30PM

3. Time of Death

4a. Facility Name (If not Institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

184-09-8795

6. Sex

1XXM 2□F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 29, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1□Yes 2XXNo

10e. Street and Number

614 Charles Street Avenue

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1□Never Married

2XXMarried

3□Widowed

4□Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1□Yes

2XXNo

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□Yes

2XXNo

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Elevator Inspector

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Harry Llewellyn

Seher

18. Mother's Name (First, Middle, Maiden Surname)

Waples

19a. Informant's Name/Relationship (Type, Print)

Ronald H Seher

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33 Medinah Drive Shillington Pennsylvania 19607

20a. Method of Disposition

1XXBurial

2□Cremation

3□Removal from State

4□Donation

5□Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

2/13/97

20c. Location - City or Town, State

Lutherville, Maryland

21. Signature of Funeral Service Licensee

Dennis S. Vesper

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 h

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Chronic Asthmatic Bronchitis

23b. Did tobacco use contribute to the cause of death?

1□Yes 2XXNo 3□Probably 4□Unknown

24a. Was an autopsy performed?

1□Yes 2XXNo

24b. Were autopsy findings available prior to completion of cause of death?

1□Yes 2□No

25. Was case referred to medical examiner?
1□Yes 2XXNo

Hospital:

1XXInpatient

2□ER/Outpatient

3□DOA

26. Place of Death (Check only one)

Other:

4□Nursing Home

5□Residence

6□Other (Specify)

27. Manner of Death

1□Natural

5□Pending investigation

2□Accident

6□Could not be determined

3□Suicide

4□Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□Yes

2□No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1XXCertifying Physician

2□Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D33897

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Robert Vissing 4300 North Charles Street Baltimore, Maryland 21218

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04165

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|---|----|--------------------------|--|----|--------------------|----|--|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Louise O. Sewell | | | | 2. Date of Death
Month Day Year
January 28, 1997 | | | | 3. Time of Death
4:35 pm | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
2000 Odell Ave | | | | 4b. City, Town, or Location of Death
Balto. MD | | | | 4c. County of Death
N/A | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
217-38-7443 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
55 Yrs. | | 8. Date of Birth (Month, Day, Year)
9-1-41 | | 9. Birthplace (State or Foreign Country)
MD | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | |
| 10e. Street and Number
2000 Odell Ave., Apt. 1220 | | | | 10f. Zip Code
21220 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | | | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 N/A College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
None | | | | | | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Robert Baskerville | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Doris Baskerville | | | | | | | | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Gregory Sewell | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4309 Marble Hall Rd. | | | | | | | | | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cemetery | | Date
2-6-97 | | 20c. Location - City or Town, State
Baltimore City | | | | | | | | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Irvin Carroll Funeral Home
1712-14 W. North Ave. Balto., MD 21217 | | | | | | | | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>congestive heart failure</td> <td rowspan="4"> Approximate Interval Between Onset and Death

 2 yrs
5 yrs </td> </tr> <tr> <td>b.</td> <td>chronic bronchitis</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | congestive heart failure | Approximate Interval Between Onset and Death

2 yrs
5 yrs | b. | chronic bronchitis | c. | | d. | |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | congestive heart failure | Approximate Interval Between Onset and Death

2 yrs
5 yrs | | | | | | | | | | | | | | | | |
| | b. | chronic bronchitis | | | | | | | | | | | | | | | | | |
| | c. | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D 29769 | | 29d. Date signed (Month, Day, Year)
2/3/97 | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Form 23a) (Type, Print)
Mrs. Cecelia D. Davidson-Randall 516 N. Rolling Rd. Annapolis, MD | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM:10e per FH G-744 2-13-97 eoh

Certificate of Death

Reg. No.

97 04166

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JESSIE SILVERMAN

2. Date of Death
Month Day YearFEBRUARY 11th 1997

3. Time of Death

7:29 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral
Director

5. Social Security Number

212-09-2185D

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

MARCH 19, 1904 MD

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7211 BROOKCREST WAY #B-3

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LLOYD

KRAMER

18. Mother's Name (First, Middle, Maiden Surname)

SARAH

GOLDBERG

19a. Informant's Name/Relationship (Type, Print)

EUNICE SMITH / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3614 LABYRINTH ROAD BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH TFILOH

Date

2/12/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PULMONARY EDEMA

Due to (or as a consequence of):

2 WEEKS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

2 WEEKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY COMPROMISE

RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

AS 2402321 DE 9007

29d. Date signed (Month, Day, Year)

FEBRUARY 11th 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SINAI HOSPITAL, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MARYLAND 21215

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04167

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CALVIN A.

SIMMONS

2. Date of Death

Month

Day

Year

FEBRUARY 12, 1997

3. Time of Death

4:20 AM

4a. Facility Name (If not institution, give street and number)

Gilcrest Hospice

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

243-80-7208

6. Sex

M 2 F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 29, 1948

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes 2 No

10e. Street and Number

4405 Parkwood Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Baltimore City
Dept. Of Education

17. Father's Name (First, Middle, Last)

Calvin A. Simmons

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Johnson

19a. Informant's Name/Relationship (Type, Print)

Dianne Simmons wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4405 Parkwood Avenue Baltimore, Md. 21206

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

Feb. 15 Baltimore, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward R. Terry Jr.

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. metastatic lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

Hospice

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

NA

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

W.A. Riley

G. B. Bink

6701 N. Charles St. Balto., MD

21205

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

u

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04168

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Webster Taylor, Jr.

2. Date of Death

Feb. 11, 1997

3. Time of Death

0420 a.m.

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

Funeral
Director

5. Social Security Number

220-01-6237

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 12, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

230 Timbergrove Rd.

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Steel Manufacture

17. Father's Name (First, Middle, Last)

William Webster Taylor Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Hawkins

19a. Informant's Name/Relationship (Type, Print)

William W. Taylor III Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

230 Timbergrove Rd., Reisterstown, Md. 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Lukes Ch. Cem. 02/14/97

Date

20c. Location - City or Town, State

Reisterstown, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Eckhardt Funeral Chapel

11605 Reisterstown Rd., Owings Mills, Md.

21117

23a. Pert. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pulmonary embolism

Due to (or as a consequence of):

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Phlebothrombosis

Due to (or as a consequence of):

Hours

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic vascular disease

Peripheral gangrene

Adult onset diabetes melitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Daniel A Symonds M.D.

29c. License number

D20397

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel A Symonds MD

Union Memorial Hosp

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04169

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE

TUCHMAN

2. Date of Death

Month Day Year
FEB. 9, 1997

3. Time of Death

8:30pm

4a. Facility Name (If not institution, give street and number)

1613 BROADWAY ROAD

4b. City, Town, or Location of Death

LUTHERVILLE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

104-20-8901

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year
NOV. 2, 1928

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State
MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2231 OLD COURT ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

Collage (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ABRAHAM

GARFINKEL

18. Mother's Name (First, Middle, Maiden Surname)

LENA

POLLACK

19a. Informant's Name/Relationship (Type, Print)

DR. DAVID TUCHMAN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1613 BROADWAY ROAD LUTHERVILLE, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

WELLWOOD CEMETERY 2-11-1997-PINELAWN, L.I., NEW YORK

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. DUE TO (or as a consequence of):

RECTAL CANCER

Approximate
Interval Between
Onset and Death

> 10 yrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. DUE TO (or as a consequence of):

c. DUE TO (or as a consequence of):

d. DUE TO (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 27730

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY COHEN, MD. 6569 N. CHARLES ST. BETH, MD. 21204

31. Date filed (Month, Day, Year)

FEB 18 1997

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04170

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Calvin O. Thaniel

2. Date of Death

February 7 1997

3. Time of Death

12:30 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3220 Normandy Woods Rd Apt D

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

218-26-1502

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 21, 1932 Md.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10e. State

Md.

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 Yes 3 No

10e. Street and Number

3220 Normandy Woods Rd. Apt D

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 6/195413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

18b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Herbert Gordon Thaniel

18. Mother's Name (First, Middle, Maiden Surname)

Rose Kenney

19a. Informant's Name/Relationship (Type, Print)

Belinda P. Thaniel

wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8893 Flowerstock Rd. Columbia, Md. 21045

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Garrison Forest Veterans Feb 12 Owings Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ernest R. Tanyfs

22. Name and Address of Facility

Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 2121623a. Part I. Enter the disease, or complications that caused the death.
Check, or heart failure. List only one cause on each line.

Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Severe Coronary Artery Disease

Due to (or as a consequence of):

c. Severe Ischemic Cardiomyopathy

Due to (or as a consequence of):

10 yr

10 yr

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident investigation
3 Suicide 6 Could not be
4 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Lucy H. Anderson

29c. License number

D28921

29d. Date signed (Month, Day, Year)

FEB 10th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Imtiaz Chowdhry M.D. 10792 Hickory Ridge Rd Columbia Md 21044

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
900-686-6000.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04171

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES VINCENT WOOD, SR.

2. Date of Death

February 7, 1997

3. Time of Death

6:19 PM

4a. Facility Name (If not institution, give street and number)

8213 Robin Hood Court

4b. City, Town, or Location of Death

Ruxton

4c. County of Death

Baltimore County

Funeral
Director

5. Social Security Number

039-07-9671

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

October 1, 1921 Rhode Island

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles County

10c. City, Town or Location

Issue

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14805 King Charles Drive

10f. Zip Code

20645

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 144-'46

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

Westinghouse Corp.

17. Father's Name (First, Middle, Last)

Vincent Louis Wood

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude F. Rafferty

19a. Informant's Name/Relationship (Type, Print)

John L. Wood, Esq. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

319 Taplow Road, Baltimore, Maryland 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Mary's Cath. Cemetery 2/11/97 Snow Shoe, Pennsylvania

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Rectal carcinoma*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lain

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John C. Downs

29c. License number

D 33624

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN C. DOWNS, M.D., 7505 Osler Drive, Towson, Maryland 21204

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

John C. Downs

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

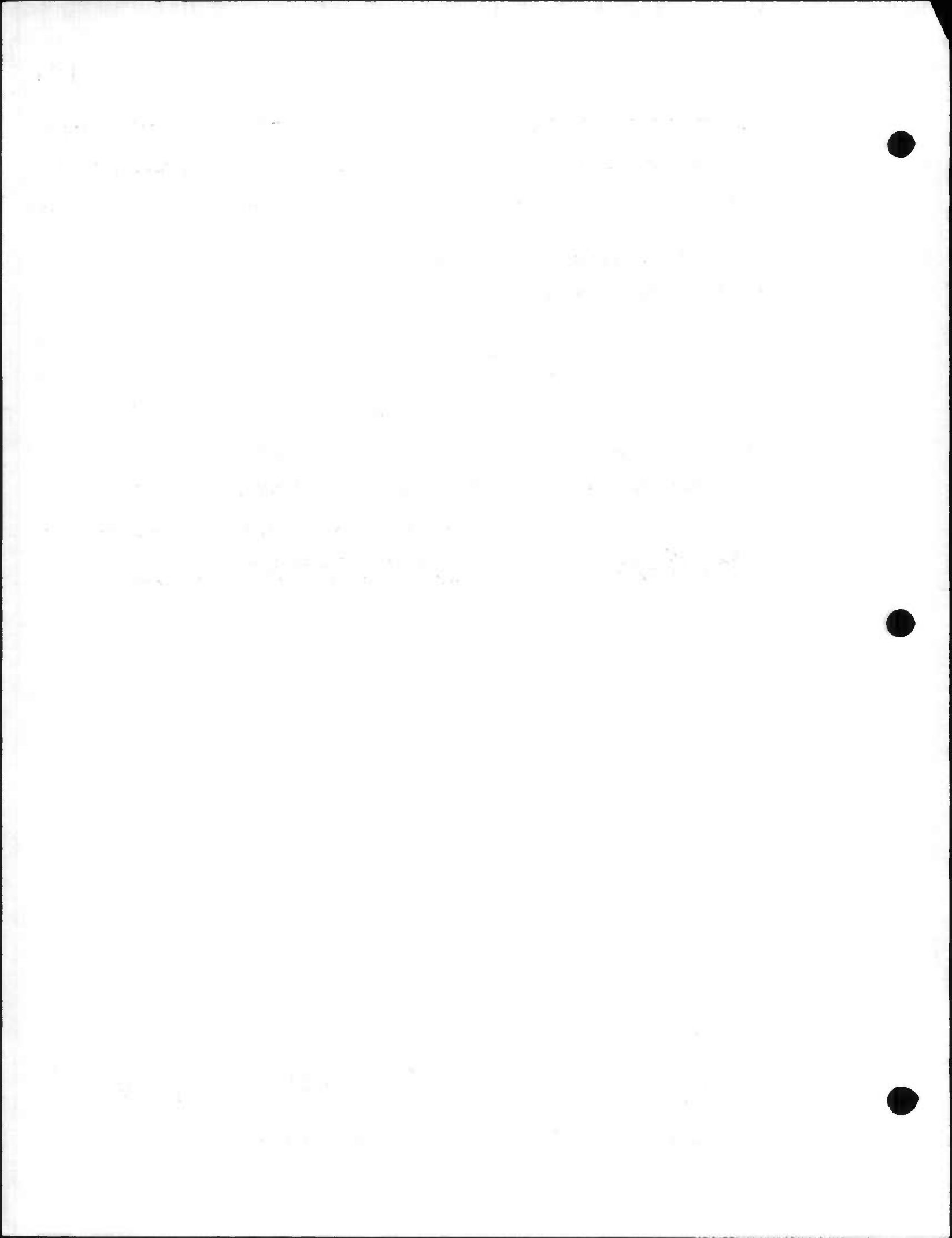
Physician
/Medical
Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04172

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GRACE WILLIAMS | | | | 2. Date of Death
Month February Day 12 Year 1997 | | 3. Time of Death
8:23 AM | |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
217-26-3509 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
JANUARY 10, 1910 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE CITY | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
822 N. MONROE | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7TH GRADE College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEKEEPER | | 16b. Kind of Business/Industry
APARTMENT COMPLEX | | | |
| | 17. Father's Name (First, Middle, Last)
ARTHUR SMOTHERS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ALBERTA (MN-UNKNOWN) | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
DORIS JACKSON (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
822 N. MONROE STREET, BALTO, MD. 21217 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARBUTUS CEMETERY | | 20c. Location - City or Town, State
2-17-97 ARBUTUS, MARYLAND | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME, P.A.
2140 N. FULTON AVE., BALTIMORE, MD. 21217 | | | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. ASCVD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death
1 hour.
10 years. | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 26. Piece of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
Jerome I. Snyder M.D. | | | | 29c. License number
D22648 | | 29d. Date signed (Month, Day, Year)
February 12, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JEROME I. SNYDER, M.D. 900 S. CATON AVENUE BALTIMORE, MD. 21229 | | | | 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
 | | | | 33. Date of Death (Month, Day, Year)
FEB 12 1997 | | | |
| | 34. Date of Death (Month, Day, Year)
FEB 12 1997 | | | | 35. Date of Death (Month, Day, Year)
FEB 12 1997 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1801. It contains a report on the state of the Union and the progress of the government during the year 1800. The letter is signed by James Madison, who was then Vice President of the United States.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 3, 1801. It contains a detailed account of the financial state of the United States, including the amount of the public debt, the revenue of the government, and the expenditures for the year 1800. The report is signed by Alexander Hamilton, who was then Secretary of the Treasury.

3. The third part of the document is a report from the Secretary of War, dated January 3, 1801. It contains a detailed account of the military state of the United States, including the number of troops, the state of the armaments, and the progress of the military operations during the year 1800. The report is signed by Henry Knox, who was then Secretary of War.

4. The fourth part of the document is a report from the Secretary of the Navy, dated January 3, 1801. It contains a detailed account of the naval state of the United States, including the number of ships, the state of the armaments, and the progress of the naval operations during the year 1800. The report is signed by John Paul Jones, who was then Secretary of the Navy.

5. The fifth part of the document is a report from the Secretary of the Interior, dated January 3, 1801. It contains a detailed account of the state of the interior of the United States, including the progress of the settlement of the western lands, the state of the Indian tribes, and the progress of the public works. The report is signed by Thomas Mifflin, who was then Secretary of the Interior.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04173

Item: 28f per MEO G-744 2/26/97 reb

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
STEPHEN DARYL WITTIG | | 2. Date of Death
Month January Day 25 Year 1997 | | 3. Time of Death
0014a |
| | 4a. Facility Name (If not institution, give street and number)
LIBERTY MEDICAL CENTER | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
213-60-4823 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)
44 Yrs. | If Under 1 Year
Months 44 Days 44 | If Under 24 Hrs.
Hours 44 Min. 44 |
| | 8. Date of Birth (Month, Day, Year)
MAY 24, 1952 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Md. | 10b. County
Carroll | 10c. City, Town or Location
Westminster | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
2551 Stone Road | | 10f. Zip Code
21158 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Service Technician | | 16b. Kind of Business/Industry
Family Heating & Air Conditioning | | |
| | 17. Father's Name (First, Middle, Last)
George Wittig | | 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Weddle | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Jeffrey Wittig - brother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10303 Citation Way, Laurel, Md. 20723 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Pk. | | 20c. Location - City or Town, State
Elkridge, Md. |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at Meadowridge
7250 Washington Blvd., Elkridge, Md. 21227 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. GUNSHOT WOUND OF CHEST AND ABDOMEN
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
01-24-97 | | 28b. Time of Injury
2340p M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
SUBJECT SHOT | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
STREET | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2200 REGISTERSTOWN RD BRYANT | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
January 25, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ann Dixon M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

2-19-97

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 16b per FH G-744 State of Maryland / Department of Health and Mental Hygiene

97 04174

ITEM: 27 per DR G-744 2-13-97 eoh

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARY WILLIAMS | | | | 2. Date of Death
Month Day Year
FEBRUARY 8 1997 | | 3. Time of Death
8:15am | |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
218-30-6130 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
89 Yrs. | If Under 1 Year
Months Days
9 12 | If Under 24 Hrs.
Hours Min.
9 12 | 8. Date of Birth (Month, Day, Year)
9-12-07 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
N/A | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
2525 EUTAW PLACE | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
US | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) -0- | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic | | | 16b. Kind of Business/Industry
HOUSEKEEPING | | |
| | 17. Father's Name (First, Middle, Last)
CHARLES WILSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANN HICKS | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Leo Williams Jr (Son) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
714 Kennedy Street, N.E. Washington DC 20011 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial Park | | 20c. Location - City or Town, State
2/14/97 BALTIMORE, MD | | | |
| | 21. Signature of Funeral Service Licensee
[Signature] CFS | | | | 22. Name and Address of Facility
Phillips F/H 1721-27 N MONROE ST. BALT MD 21217 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. LACUNAR INFARCT
Due to (or as a consequence of):
b. HYPERTENSION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
SIX DAYS |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA
PREVIOUS CEREBRAL INFARCT | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
M-D P10587 | | 29d. Date signed (Month, Day, Year)
FEBRUARY 8 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ELIZABETH BEKUI GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD BALTIMORE MD 21239-2995 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

215166591

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04175

ITEM: 24a G-744 2-13-97 per DR.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUIS WESTERMEYER, SR

2. Date of Death

Month Day Year
FEBRUARY 04-1997 11:00am

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

215-16-6591

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
MAY 16, 1922

9. Birthplace (State or Foreign Country)

BALTIMORE, MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE COUNTY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

407 OLD HOME ROAD

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

12

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELECTRICIAN

16b. Kind of Business/Industry

BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)

GEORGE H. WESTERMEYER

18. Mother's Name (First, Middle, Maiden Surname)

IRENE K. KIEPNER

19a. Informant's Name/Relationship (Type, Print)

JANETT E. WESTERMEYER (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

407 OLD HOME ROAD BALTIMORE, MARYLAND 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH CEMETERY FEBRUARY 7, 1997 BALTIMORE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

L. L. L. L. L.

22. Name and Address of Facility

LASSAHN FUNERAL HOME, INC.
7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio-respiratory arrest
Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aortic-encephalopathy
Due to (or as a consequence of):c. cardiac arrest secondary to ventricular fibrillation 30 min
Due to (or as a consequence of):

d. with resuscitation

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- infective endocarditis

- status post bilateral knee replacement for infected prosthesis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. J. J.

29c. License number

P01853

29d. Date signed (Month, Day, Year)

FEBRUARY-04-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACQUES KPODONU 5601 LOCH RAVEN BLVD BAITO MD 21239

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: 16b G-744 per FH 2-13-97 eoh

Certificate of Death

Reg. No.

97 04176

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE FRANK WILLIAMS

2. Date of Death

Month Day Year
February 11, 1997

3. Time of Death

7:16am

4a. Facility Name (If not institution, give street and number)

3909 Barrington Road (res.)

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

578-07-5557

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
04/16/1900

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3909 Barrington Road

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

COUNTRY CLUB

~~Country Club~~

17. Father's Name (First, Middle, Last)

Henry Williams

18. Mother's Name (First, Middle, Maiden Surname)

Anna Miller

19a. Informant's Name/Relationship (Type, Print)

Ellis Johnson, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3141 Jeffland Road, Baltimore, MD 21244

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Valley Mem. Grd.

2/15

Date

20c. Location - City or Town, State

Annandale, Virginia

21. Signature of Funeral Service Licensee

Leroy O. Dyett

22. Name and Address of Facility

LEROY O. DYETT & SON FUNERAL HOME, P.A.
4600 LIBERTY HEIGHTS AVE., BALTO. 21207

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Massive aspiration*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Pseudo-bulbar palsy & dysphagia*
Due to (or as a consequence of):

c. *Hypertensive cerebrovascular cerebrovascular disease*
Due to (or as a consequence of):

d. *& multiple strokes*

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David J. Penn MD

29c. License number

D20928

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David J. Penn MD 3635 OLD COURT RD

21244

31. Date filed (Month, Day, Year)

FEB 13 1997

32. Registrar's Signature

Wilson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97 04177

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
<i>Dorothy Lenore Aynes</i> | | | | 2. DATE OF DEATH
MONTH <i>1</i> DAY <i>17</i> YEAR <i>97</i> | | 3. TIME OF DEATH
<i>4:00 A M</i> | |
| 4. SOCIAL SECURITY NUMBER
<i>217-18-8878</i> | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (in yrs. last birthday)
<i>88</i> YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
<i>10/25/09</i> | |
| 8. BIRTHPLACE (State or Foreign Country)
<i>Ranson WV</i> | | | | 9a. FACILITY NAME (If not institution, give street and number)
<i>Frederick Memorial Hospital</i> | | 9b. CITY, TOWN OR LOCATION OF DEATH
<i>Frederick</i> | |
| 9c. COUNTY OF DEATH
<i>Frederick</i> | | | | 10a. STATE
<i>Maryland</i> | | 10b. COUNTY
<i>Frederick</i> | |
| 10c. CITY, TOWN OR LOCATION
<i>Brunswick</i> | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 10e. STREET AND NUMBER
<i>223 East Potomac Street</i> | |
| 10f. ZIP CODE
<i>21716</i> | | | | 10g. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: <i>White</i> | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i></i> | | | | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
<i>Bartender</i> | | 16b. KIND OF BUSINESS/INDUSTRY
<i>Brunswick Moose Lodge</i> | |
| 17. FATHER'S NAME (First, Middle, Last)
<i>Royal Greaver</i> | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
<i>Nancy Engenia Ware</i> | | | |
| 19a. INFORMANT'S NAME (Type/Print)
<i>Lavania M. Green</i> | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>223 E. Potomac St. Brunswick MD 21716</i> | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
<i>Park Heights Cemetery</i> | | 20c. LOCATION — City or Town, State
<i>Brunswick, MD</i> | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>Barbara A. Williams, Owner</i> | | | | 22. NAME AND ADDRESS OF FACILITY
<i>John T. Williams Funeral Home
100 Petersville Rd Brunswick MD 21716</i> | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. apparent acute myocardial infarction</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. arteriosclerotic cardiovascular disease</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
<i>M</i> | |
| 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>W. H. Hain M.D.</i> | | | | 29c. LICENSE NUMBER
<i>D16675</i> | | 29d. DATE SIGNED (Month, Day, Year)
<i>1/17/97</i> | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
<i>LYNNE ALLGATER M.D., BRUNSWICK, MD 21716</i> | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
<i>JAN 23 1997</i> | | | | 32. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

97 04178

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
June Clark Anders | | | | 2. DATE OF DEATH
MONTH DAY YEAR
January 30, 1997 | | 3. TIME OF DEATH
11:45 P M | |
| 4. SOCIAL SECURITY NUMBER
217-46-9523 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
73 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
Aug. 9, 1923 | |
| 8. BIRTHPLACE (State or Foreign Country)
PA | | | | 9a. FACILITY NAME (If not institution, give street and number)
Wesleyan Health Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH
Denton | |
| 9c. COUNTY OF DEATH
Caroline | | | | 10a. STATE
MD | | 10b. COUNTY
Caroline | |
| 10c. CITY, TOWN OR LOCATION
Denton | | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 10e. STREET AND NUMBER
410 Colonial Dr. | |
| 10f. ZIP CODE
21629 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Home | |
| 17. FATHER'S NAME (First, Middle, Last)
Harden Clark | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Zelma Emery Clark | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Larry W. Anders | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23150 Tuckahoe Springs Dr. Denton, MD 21629 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
MD Vet. Cem. 2/5/97 | | 20c. LOCATION — City or Town, State
Cheltenham, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
David C. Chob MO0945 | | | | 22. NAME OF FUNERAL HOME, INC.
P.O. Box 567 LaPlata, MD 20646 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Interstitial Lung Disease</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. <u>Rheumatoid arthritis</u>
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | |
| 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER
(Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
James Sides MD | | | | 29c. LICENSE NUMBER
D3376 | | 29d. DATE SIGNED (Month, Day, Year)
1-31-97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James Sides, M.D., PO Box 496, Denton, Maryland 21629 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 03 1997 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson Randall | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

97 04179

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Ruben Artis | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Jan. 19, 1997 | | | | 3. TIME OF DEATH
12:15 A M | | | | | |
| 4. SOCIAL SECURITY NUMBER
223-48-5294 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept. 8, 1938 | | 8. BIRTHPLACE (State or Foreign Country)
Sedley, Va. | |
| 9a. FACILITY NAME (If not institution, give street and number)
2007 Chadwick Terr. | | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Temple Hills | | | | 9c. COUNTY OF DEATH
Prince Georges | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Prince Georges | | 10c. CITY, TOWN OR LOCATION
Temple Hills | | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 10e. STREET AND NUMBER
2007 Chadwick Terr. | | | | | | 10f. ZIP CODE
20748 | | | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Recreational Planner | | | | 16b. KIND OF BUSINESS/INDUSTRY
State of Maryland | | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
James Artis | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bessie Turner Artis | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Yvonne Ricks Artis | | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2007 Chadwick Terr., Temple Hills, Md., 20748 | | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
ARTIS Family Cem. 1/25/97 | | | | 20c. LOCATION — City or Town, State
Sedley, Va. | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
WJ Jeffers | | | | | | 22. NAME AND ADDRESS OF FACILITY
Frazier Funeral Home
389 Rhode Island Av., NW, Washington | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):
Approximate Interval Between Onset and Death
6 years | | | | | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. MANNER OF DEATH
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Harvey K. Teer | | | | | | 29c. LICENSE NUMBER
D 20352 | | | | 29d. DATE SIGNED (Month, Day, Year)
1/24/97 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Harvey K. Teer MD 8926 Woodward Rd Clarks MD 20735 | | | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 28 1997 | | | | 32. REGISTRAR'S SIGNATURE
John Andrew Randall | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04180

Items: 23 part I, 27 per MEO G-745 3/18/97 re **Certificate of Death**

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JEREMY TODD BIDDLE | | | | 2. Date of Death
Month Day Year
FEB. 05, 1997 | | 3. Time of Death
2010 PM | |
| | 4a. Facility Name (If not institution, give street and number)
UNION MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
ELKTON | | 4c. County of Death
CECIL | |
| Funeral
Director | 5. Social Security Number
213-11-8212 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
18 Yrs. | | 8. Date of Birth (Month, Day, Year)
June 9, 1978 | |
| | 9. Birthplace (State or Foreign Country)
Delaware | | 10a. State
Maryland | | 10b. County
Cecil | | 10c. City, Town or Location
Elkton | |
| To Be Completed by Funeral Director | 10e. Street and Number
116 South Tartan Drive | | | | 10f. Zip Code
21921 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | 16b. Kind of Business/Industry | | | |
| | 17. Father's Name (First, Middle, Last)
Francis M. Biddle, Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Beverly Badur | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Beverly Badur-Betts/mother | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
116 South Tartan Drive, Elkton, Maryland 21921 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Georges Cemetery | | 20c. Location - City or Town, State
2/8/97 St. Georges, Delaware | | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton St., Elkton, Maryland 21921 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CARDIAC ARRHYTHMIA
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> MD | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
FEB. 6, 1997 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Maryann D. Korman 111 Penn Street, Baltimore, Maryland 21201 | | | | 31. Date filed (Month, Day, Year)
FEB 13 1997 | | | |
| | 32. Registrar's Signature
<i>[Signature]</i> | | | | 33. State Registrar
State Registrar | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Amended # 8, 1/29/97
NAB, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

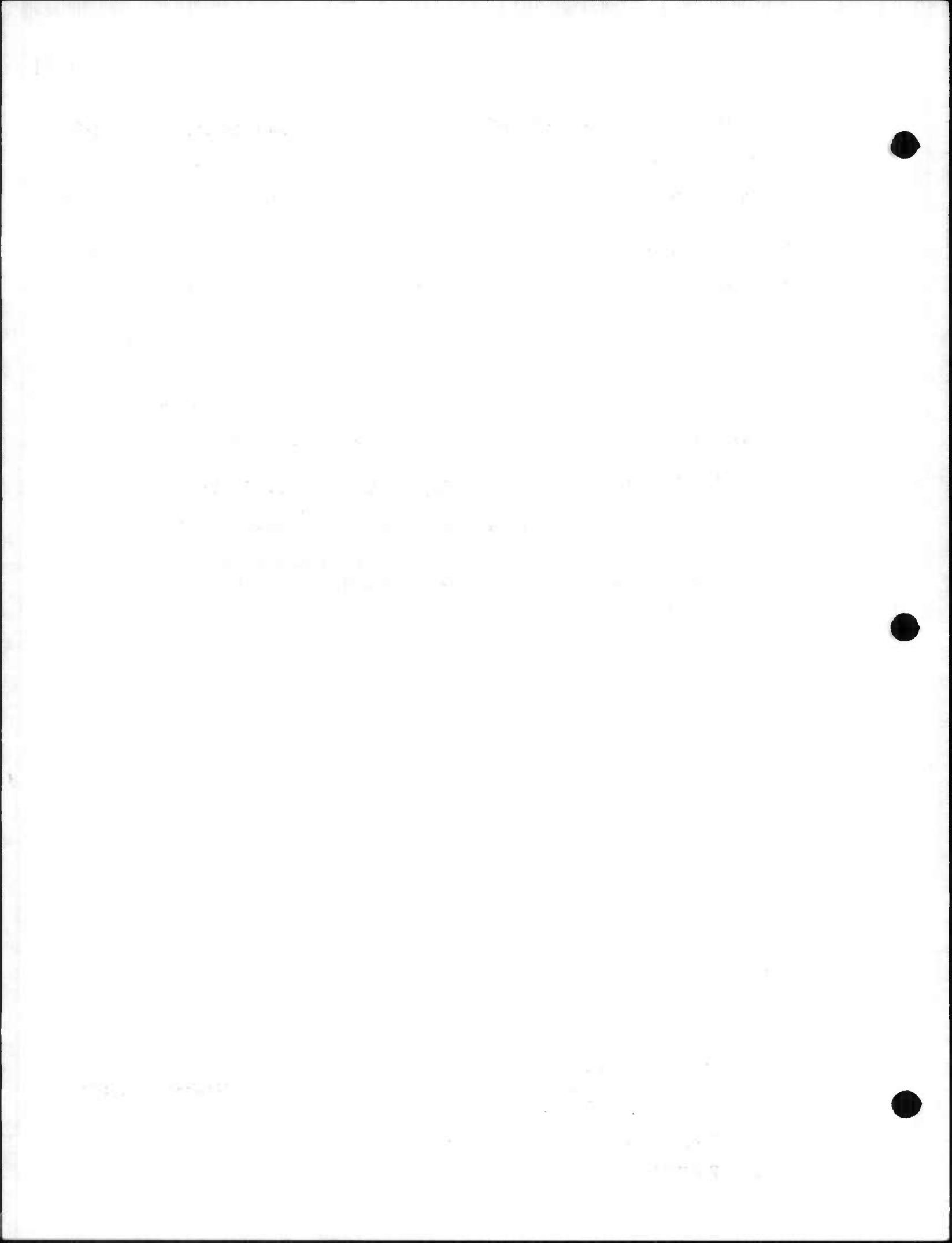
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04181

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruth T. Buskirk | | | | 2. Date of Death
Month Day Year
JANUARY 24, 1997 | | 3. Time of Death
1900 | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | |
| Funeral
Director | 5. Social Security Number
215-12-2218 | 6. Sex
1 <input type="checkbox"/> M 3 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Feb. 28, 1920 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | | |
| | 10a. State
Maryland | | 10b. County
Allegany | | 10c. City, Town or Location
Lonaconing | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
13 Rockville St. | | | 10f. Zip Code
21539 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0 | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | |
| | 17. Father's Name (First, Middle, Last)
Joseph Snyder | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Beeman | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Paul Buskirk-son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Box 71, Lonaconing, Md. 21539 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Cemetery | | Date
Jan. 27, 1997 | | 20c. Location - City or Town, State
Lonaconing, Md. | |
| | 21. Signature of Funeral Service Licensee
<i>John E. Miller</i> | | | 22. Name and Address of Facility
Eichhorn-McKenzie Funeral Home
Lonaconing, Md. 21539 | | | | |
| | 23a. (Part I) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. <i>CORONARY ARTERY DISEASE</i>
Due to (or as a consequence of):
b. <i>DIABETES MELLITUS</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
Unknown
Unknown |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>POLYCYSTIC KIDNEY DISEASE WITH END STAGE RENAL DISEASE</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
<i>Robert Welik</i> | | 29c. License number
D31875 | | 29d. Date signed (Month, Day, Year)
JANUARY 25, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Robert Welik MD 902 Seton Drive Cumberland MD 21502</i> | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | 32. Registrar's Signature
<i>John Anderson Randall</i> | | | | | | |




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State of Maryland / Department of Health and Mental Hygiene

97 04182

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEONA MAE BOOTMAN | | | | 2. Date of Death
Month Day Year
JANUARY 28, 1997 | | 3. Time of Death
1330 | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
214-07-3434 a | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
August 9, 1911 | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Allegany | 10c. City, Town or Location
Frostburg | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | 10a. Street and Number
16412 Clarysville Road | | | 10f. Zip Code
21532 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0 | | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
laborer | | 18b. Kind of Business/Industry
Textiles | | | |
| | 17. Father's Name (First, Middle, Last)
David Yates | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Stevens | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Gladys Klosterman | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
34637 Petunia Place Zephyrhills Florida 33541 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Methodist Cemetery | | Date
Jan. 31, 1997 | 20c. Location - City or Town, State
Vale Summit, Maryland | | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Durst Funeral Home P.A.
57 Frost Avenue Frostburg, Maryland 21532 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
a. <u>Death C.H.F. E</u>
Due to (or as a consequence of):
b. <u>Multi system failure</u>
Due to (or as a consequence of):
c. <u>urosepsis</u>
Due to (or as a consequence of):
d. | | | | | | | 24 h
24 h
7 days |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24e. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D08377 | | 29d. Date signed (Month, Day, Year)
JANUARY 29, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Uriel Velandia, M.D. 924 Seton Drive Cumberland MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 30 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04183

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VIRGINIA MAE BANTZ | | 2. Date of Death
Month January Day 30 Year 1997 | | 3. Time of Death
12:20 pm |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany |
| Funeral
Director | 5. Social Security Number
219-34-6279 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
79 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Dec. 27, 1917 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location
LAVALE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. State
MARYLAND | 10b. County
ALLEGANY | | | |
| | 10e. Street and Number
552 NATIONAL HIGHWAY | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4or 5+) | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
HOME |
| | 17. Father's Name (First, Middle, Last)
CLARENCE GARDNER | | 18. Mother's Name (First, Middle, Maiden Surname)
NELLIE JUNKINS | | |
| | 19a. Informant's Name/Relationship (Type, Print)
CLYDE EDWARD BANTZ / SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115 HUMBIRD STREET - CUMBERLAND, MD 21502 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PHILO CEMETERY | | 20c. Location - City or Town, State
WESTERNPORT, MD |
| | 20. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
GEORGE-UPCHURCH FUNERAL HOME, P.A.
202 GREENE ST., CUMBERLAND, MD 21502 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Immediate Cause (Final disease or condition resulting in death)
e. CHRONIC OBSTRUCTIVE RESPIRATORY FAILURE 2° TO PULMONARY DISEASE
Due to (or as a consequence of):
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____ | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PERFORATED DUODENAL ULCER | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day Year) | | | | | |
| 28b. Time of injury
M <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | | | | |
| 29c. License number
D 14865 | | | | | |
| 29d. Date signed (Month, Day, Year)
January 31 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, MD 21502 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 03 1997 | | | | | |
| 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

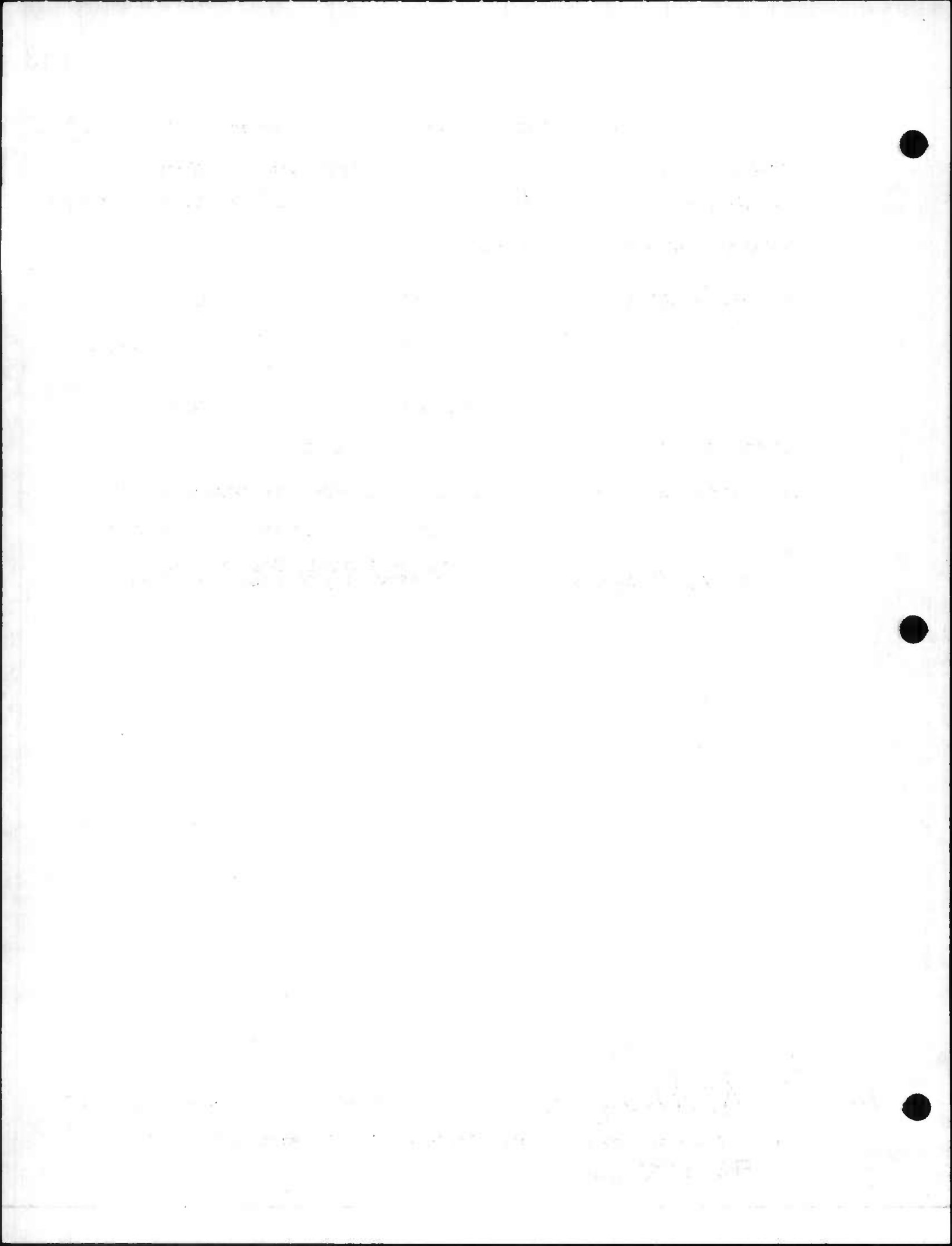
Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04184

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN A. BOWSER | | | | 2. Date of Death
Month Day Year
JANUARY 19, 1997 | | | | 3. Time of Death
4:10 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
GARRETT MEMORIAL HOSPITAL | | | | 4b. City, Town, or Location of Death
OAKLAND | | | | 4c. County of Death
GARRETT | |
| Funeral
Director | 5. Social Security Number
212 24 1187 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
AUG. 9, 1905 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | 10c. City, Town or Location
MARKLEYSBURG BORO | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10a. State
PA | | 10b. County
FAYETTE | | 10e. Street and Number
Route #281 South | | | | 10f. Zip Code
15459 | |
| | 10g. Citizen of What Country?
U.S. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1944 | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8 | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SAWYER | | | | 16b. Kind of Business/Industry
TIMBER | | | | 17. Father's Name (First, Middle, Last)
JOSEPH BOWSER | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
VICTORIA BATES | | | | 19a. Informant's Name/Relationship (Type, Print)
BEATRICE BOWSER/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P. O. BOX 171, MARKLEYSBURG, PA 15459 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ASHER GLADE CEM. | | | | 20c. Location - City or Town, State
1/22/97 FRIENDSVILLE, MD | |
| | 21. Signature of Funeral Service Licensee
 D00099 | | | | 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A.
60 W. MAIN ST., FROSTBURG, MD 21532 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>atherosclerotic cardiovascular disease</u>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. <u>atherosclerotic cardiovascular disease</u>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D25759 | | | | 29d. Date signed (Month, Day, Year)
January 19, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Walter K. Naumann, M.D., PO Box 247, 106 Cemetery Road, Accident, Md. | | | | 31. Date filed (Month, Day, Year)
FEB 03 1997 | | | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04185

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KEITH E. BOBO | | | | 2. Date of Death
Month Day Year
January 24 1997 | | 3. Time of Death
5:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital & Medical Center | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| Funeral
Director | 5. Social Security Number
233-50-3553 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
63 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 10, 1933 | | 9. Birthplace (State or Foreign Country)
West Virginia |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Allegany | | 10c. City, Town or Location
Rawlings | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
21908 McMullen Highway, S.W. | | | | 10f. Zip Code
21557 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1958-1974 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Chef/Cook | | 16b. Kind of Business/Industry
US Navy | |
| | 17. Father's Name (First, Middle, Last)
Nelson Bobo | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ollie Sherman | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Pearl D. Bobo | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 972 Keyser, WV 26726 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dawson Cemetery | | Data
Jan. 27 1997 | | 20c. Location - City or Town, State
Dawson, Maryland | |
| | 21. Signature of Funeral Service Licensee
Brian L. Smith | | | | 22. Name and Address of Facility
Rotruck-Smith Funeral Home
85 S. Main Street Keyser, WV 26726 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Advanced metastatic carcinoma to lungs; primary
Dua to (or as a consequence of): unknown
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
Dr. Q. Zaman MD | | | | 29c. License number
D 23371 | | 29d. Date signed (Month, Day, Year)
January 27 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Q. Zaman Johnson Heights Medical Building Cumberland, MD. 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 04 1997 | | | | 32. Registrar's Signature
Julia Anderson-Rodall | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

97 04186

DMMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

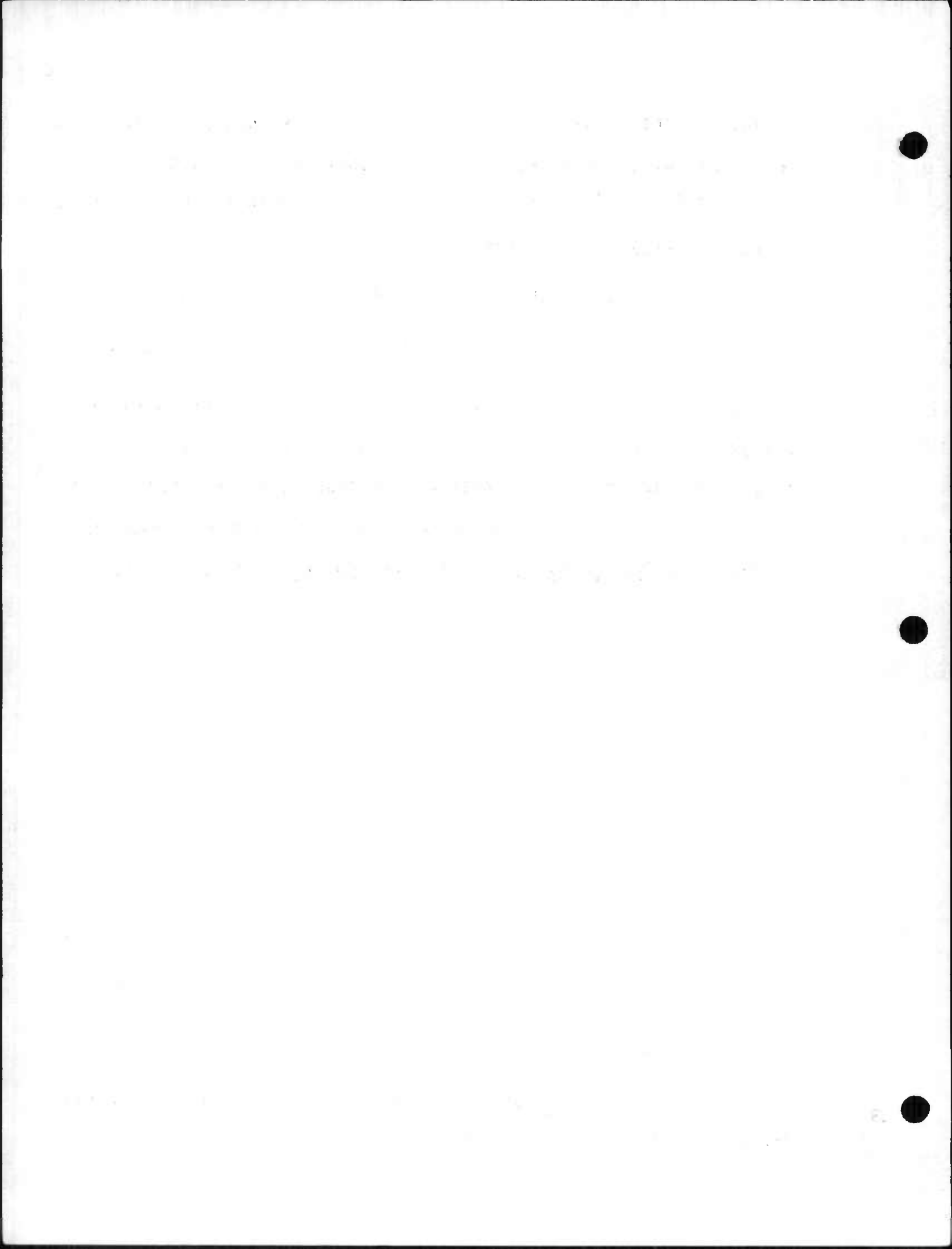
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04187

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MIRANDA LOUISE BUSHEY | | | | 2. Date of Death
Month Day Year
January 30, 1997 | | | | 3. Time of Death
5:51 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Prince George's Hospital Center | | | | 4b. City, Town, or Location of Death
Cheverly | | | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
217-13-3353 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
15 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 6, 1981 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Charles | | 10c. City, Town or Location
Hughesville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
15205 Deborah Drive | | | | 10f. Zip Code
20637 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10 | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Student | | | | 16b. Kind of Business/Industry
High School | | | | 17. Father's Name (First, Middle, Last)
William Bernard Bushey | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Linda Kay Weeks | | | | 19a. Informant's Name/Relationship (Type, Print)
William B. Bushey | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15205 Deborah Drive, Hughesville, MD 20637 | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Memorial Gardens | | | | 20c. Location - City or Town, State
1-31-97 Waldorf, MD | |
| | 21. Signature of Funeral Service Director
Benjamin Matthews M00658 | | | | 22. Name and Address of Facility
Hunt Funeral Home, Inc.
P. O. Box 156, Waldorf, MD 20604-0156 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
a. cerebral edema
b. anoxic encephalopathy
c. cerebral contusion
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval between Onset and Death
4 days
4 days
1 day | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year)
1/26/97 | | | | 28b. Time of Injury
M | | | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred
motor vehicle | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Rt 228 Indian Head | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Dr. James Catevenis, M.D. | | | | 29c. License number
P30318 | |
| | 29d. Date signed (Month, Day, Year)
1/30/97 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. James Catevenis, PG HOSPITAL CENTER, Cheverly, MD | | | | 31. Date filed (Month, Day, Year)
FEB 04 1997 | |
| | 32. Registrar's Signature
Miranda Bushey | | | | 33. State Registrar
FEB 04 1997 | | | | 34. State Registrar
FEB 04 1997 | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04188

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Maxine Barr

2. Date of Death

Month

Day

Year

1

29

97

3. Time of Death

1:45 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Residence: 273 Principio Road

4b. City, Town, or Location of Death

Port Deposit

4c. County of Death

Cecil

5. Social Security Number

217-40-1577

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Aug. 25, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Port Deposit

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

273 Principio Road

10f. Zip Code

21904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Twelve Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Personal Residence

17. Father's Name (First, Middle, Last)

Wilbert R. Harwi

18. Mother's Name (First, Middle, Maiden Surname)

Marietta Baker

19a. Informant's Name/Relationship (Type, Print)

Louis H. Barr (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

273 Principio Road, Port Deposit, Maryland 21904

20a. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Asbury Cemetery

Date

2/1/97

20c. Location - City or Town, State

Port Deposit, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home
Perryville, Maryland 21903

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lung cancer

Due to (or as a consequence of):

16 months

c. _____

Due to (or as a consequence of):

d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 23809

29d. Date signed (Month, Day, Year)

1/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

L. Austin Doyle, M.D., Greenwald Cancer Ctr., 22 S. Greene St., Balt., MD 21201

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04189

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|--|---|--|--|---|---|---|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marie Bankett | | | | | 2. Date of Death
Month January Day 27 Year 1997 | | 3. Time of Death
2:30 PM | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Prince Georges Medical Center | | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince Georges | | | | |
| Funeral
Director | 5. Social Security Number
577-24-4558 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (in yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 06, 1906 | | 9. Birthplace (State or Foreign Country)
Virginia | | | |
| | Usual Residence of Decedent | | | | | 10a. State
Washington, D.C. | | 10b. County | | 10c. City, Town or Location
Washington, D.C. | | |
| To Be Completed by Funeral Director | 10e. Street and Number
1240 Forty-Sixth Street, S.E. | | | | | 10f. Zip Code
20019 | | 10g. Citizen of What Country?
U.S.A. | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Melvin Broadus | | | | | 18. Mother's Name (First, Middle, Maiden Sumame)
Ellen Broadus | | | | | 19a. Informant's Name/Relationship (Type, Print)
Eunice Harrison | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Mem. Park | | 20c. Location - City or Town, State
Landover, Md. | | 21. Signature of Funeral Service Licensed
W. J. Jeffers | | |
| Physician
/Medical
Examiner | 22. Name and Address of Facility
Frazier Funeral Home
389 Rhode Island Av., N.W., Washington, D.C., 20001 | | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Pneumonia
Leukopenia | | | | | Approximate Interval Between Onset and Death
11 | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760, | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | 29b. Signature and title of certifier
W. J. Jeffers | | | | | 29c. License number
D41878 | |
| | 29d. Date signed (Month, Day, Year)
1-27-97 | | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
PA H. J. M. J. | | | | | 31. Date filed (Month, Day, Year)
JAN 31 1997 | |
| State Registrar | 32. Registrar's Signature
Richard Randall | | | | | 33. Date of Death
1-27-97 | | | | | 34. Time of Death
2:30 PM | |
| | 35. Date of Death
1-27-97 | | | | | 36. Time of Death
2:30 PM | | | | | 37. Signature of Registrar
Richard Randall | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04190

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|---|--|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DANIEL FRANK BLACK | | | | 2. Date of Death
Month JANUARY Day 17 Year 1997 | | | | 3. Time of Death
1:20AM | |
| | 4a. Facility Name (If not institution, give street and number)
FT. WASHINGTON MEDICAL 11711 LIVINGSTON RD | | | | 4b. City, Town, or Location of Death
FT. WASHINGTON | | | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
364-26-9313 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
71 Yrs. | | 8. Date of Birth (Month, Day, Year)
3-5-1925 | | 9. Birthplace (State or Foreign Country)
MICHIGAN | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
ACCOKEEK | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
P.O. BOX 245 | | | | 10f. Zip Code
20607 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5+ College (1-4or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
LABOR RELATIONS SPECIALIST | | | 16b. Kind of Business/Industry
U.S. FEDERAL GOV'T. | | | |
| | 17. Father's Name (First, Middle, Last)
NEIL BLACK | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MILDRED WESTBROOK | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
BETTY BLACK | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. BOX 245, ACCOKEEK, MARYLAND 20607 | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GEORGETOWN MED. SCHOOL | | | Date
1/17/97 | | 20c. Location - City or Town, State
WASHINGTON, D.C. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH STREET N.W. WASH, D.C 20011 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death)
ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
CORONARY ARTERY DISEASE
Due to (or as a consequence of):
CARCINOMA
Due to (or as a consequence of): | | | | | | | | |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MYELODYSPLASTIC DISEASE
ANEMIA
CARCINOMA | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D13072 | | | 29d. Date signed (Month, Day, Year)
1/17/1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GURBUX NACHNANI, MD. 8926 WOODYARD ROAD #601, CLINTON, MD. 20735 | | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JAN 27 1997 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04 191

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNETTE BRANDON

2. Date of Death

Month Day Year JANUARY 23, 1997 6 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Prince George's General

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

241527979

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year Nov 18, 1935

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State VA

10b. County Prince William

10c. City, Town or Location Woodbridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12504 OAKWOOD DRIVE

10f. Zip Code

22192

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

18b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

James W. Davis

18. Mother's Name (First, Middle, Maiden Surname)

Alberta Kerns

19a. Informant's Name/Relationship (Type, Print)

Albertus Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7501 Harrison Lane, Temple Hill, MD 20748

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Huntersville Mission

Date

1/31/97

20c. Location - City or Town, State

Huntersville, NC

21. Signature of Funeral Service Licensee

Nelson E. Greene

22. Name and Address of Facility

GREENE FUNERAL HOME
814 Franklin Street
Alexandria, VA 2231423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

brain tumor

Approximate
Interval Between
Onset and Death

unkn.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

stroke, aneurysms, emphysema,
arteriosclerosis, anemia,
pulmonary fibrosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lewi Dennis

29c. License number

D01499

29d. Date signed (Month, Day, Year)

Jan. 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lewi Dennis 6201 Greenbelt Rd Suite 4-1, College Park, MD 20740

31. Date filed (Month, Day, Year)

JAN 27 1997

32. Registrar's Signature

John Anderson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. 1. 1.

100

— 211 —

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

THE UNIVERSITY OF CHICAGO
 5408 S. UNIVERSITY AVE.
 CHICAGO, ILL. 60637

1. *Chrysomelidae* 2. *Chrysomelidae*

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04192

Reg. No.

| | | | | | | | | | | |
|---|---|--|---|--|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<div style="text-align: center;">Robert Coile BAUMANN</div> | | | | | 2. Date of Death
Month Day Year
January 25 1997 | | 3. Time of Death
10:38 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
Doctors' Community Hospital | | | | | 4b. City, Town, or Location of Death
Lanham | | 4c. County of Death
Prince George's | | |
| Funeral
Director | 5. Social Security Number
226 26 1110 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 8, 1926 | | 9. Birthplace (State or Foreign Country)
Virginia | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Seabrook | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
9308 Woodberry Street | | | | | 10f. Zip Code
20706 | | 10g. Citizen of What Country?
United States | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
4 | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Engineer | | | 16b. Kind of Business/Industry
U.S. Government | | | |
| 17. Father's Name (First, Middle, Last)
Charles N. Baumann | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carolyn Spann | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Evelyn F. Baumann Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9308 Woodberry Street Seabrook Maryland 20706 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial Gardens | | | Data
1/29/97 | | 20c. Location - City or Town, State
Davidsonville Md. | | |
| 21. Signature of Funeral Service Licensee
Robert E. Evans Pres | | | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p style="text-align: center;">Coronary Artery Disease</p> <p>Due to (or as a consequence of):</p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p style="text-align: center;">unknown</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
Rensen | | | | | 29c. License number
D19446 | | 29d. Date signed (Month, Day, Year)
January 27, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. Rensen, MD Doctors Community Hospital, 8118 Good Luck Road, Lanham, MD 20706 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | | 32. Registrar's Signature
[Signature] | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04193

Certificate of Death

Reg. No.

| | | | | | | | |
|---|--|--|--|--|--|--------------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARCUS ANTHONY BERRY | | | 2. Date of Death
Month Day Year
JANUARY 24, 1997 | | 3. Time of Death
02:04 AM | |
| | 4a. Facility Name (If not institution, give street and number)
12901 WOODMORE ROAD | | | 4b. City, Town, or Location of Death
Mitchellville | | 4c. County of Death
PRINCE GEORGE | |
| Funeral
Director | 5. Social Security Number
215-31-5099 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
19 Yrs. | | 8. Date of Birth (Month, Day, Year)
07 03 1977 |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Bowie |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
16110 Parklawn Place | | 10f. Zip Code
20716 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th
College (1-4 or 5+) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Entrepreneur | | 16b. Kind of Business/Industry
Private | | |
| | 17. Father's Name (First, Middle, Last)
Samuel T. Berry, Jr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Lora Hicks | | 19a. Informant's Name/Relationship (Type, Print)
Samuel T. Berry Jr./Father | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16110 Parklawn Place, Bowie, Maryland 20716 |
| Physician
/Medical
Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Location - City or Town, State
Landover, Maryland | | |
| | 21. Signature of Funeral Service Licensee
Nancy A. Perentis | | 22. Name and Address of Facility
J. B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Multiple Injuries | | Approximate Interval Between Onset and Death |
| To Be Completed by Physician/Medical Examiner | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE | | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
1-24-97 |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury
0204 M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
occupant of vehicle, ejected | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
12801 Woodmore Rd. |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Daron Lake MD | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
JANUARY 24, 1997 |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARSON WOOD, MD | | 31. Data filed (Month, Day, Year)
JAN 29 1997 | | 32. Registrar's Signature
J. Larson Wood | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04194

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Butler

2. Date of Death
Month Day Year

January 24, 1997

3. Time of Death

7:50 Am

4a. Facility Name (If not Institution, give street and number)

Manor Care Nursing Home

4b. City, Town, or Location of Death

Largo

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

218-26-2361

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Feb. 19, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3747 Holloway North

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Henry Belt

18. Mother's Name (First, Middle, Maiden Surname)

Louvina Ennis

19. Informant's Name/Relationship (Type, Print)

Doris Spencer : Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3747 Holloway North Upper Marlboro, MD. 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

1/29/97 Clinton, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Rd. Landover, MD. 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Septicemia

Approximate Interval Between Onset and Death

Two weeks

Due to (or as a consequence of):

old Cerebral infarct

yrs.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Decubitus ulcer

Brain Tumor

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rakesh Anand, MD

29c. License number

D20108

29d. Date signed (Month, Day, Year)

1/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAKESH ANAND, MD 14300 GALLANTFOX LN, BOWIE MD 20715

31. Date filed (Month, Day, Year)

JAN 29 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

THE UNIVERSITY OF CHICAGO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04 195

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FLOYD BANJOMAN

2. Date of Death

Month Day Year
JAN 23 1997

3. Time of Death

11:19AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

VAMHCS

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NIA

5. Social Security Number

231-54-7920

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 17, 1944

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

901 Nadine Court

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Groom

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Hume Banjoman

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Johnson

19a. Informant's Name/Relationship (Type, Print)

Dorothy Banjoman/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

901 Nadine Court, Landover, Maryland 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

1/29/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC ADENOCARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Erica Scavella M.D.

29c. License number

P10206

29d. Date signed (Month, Day, Year)

JAN 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERICA SCAVELLA M.D., 10 S. GREENE ST., BALTIMORE, MD

31. Date filed (Month, Day, Year)

JAN 29 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04196

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|---|--------------------------------------|--|---|---|--|--|--|---|----|---------------|--|----|---------------------------------|----------------|----|------------------------------|----------------|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JULIA BROWN | | | | 2. Date of Death
Month JANUARY Day 24 Year 97 | | | | 3. Time of Death
6 PM | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Gladys Spellman Specialty Hospital | | | | 4b. City, Town, or Location of Death
Cheverly | | | | 4c. County of Death
Prince Georges | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
577-44-0539 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
October 15, 1927 | | 9. Birthplace (State or Foreign Country)
South Carolina | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by
Funeral Director | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Capitol Heights | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | |
| | 10e. Street and Number
6701 Arlene Drive | | | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 4+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Psychiatric Nurse | | | | 16b. Kind of Business/Industry
Government | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Claude Mingo | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Harris | | | | | | | | | | | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Angela Mathis/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6701 Arlene Drive, Capitol Heights, MD 20743 | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | Date
1/29/97 | | 20c. Location - City or Town, State
Landover, Maryland | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
Nancy A. Percontio | | | | 22. Name and Address of Facility
J. B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785 | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>SEPSIS</td> <td>Approximate Interval Between Onset and Death
HOURS</td> </tr> <tr> <td>b.</td> <td>CHRONIC VEGETATIVE STATE</td> <td>8 YEARS</td> </tr> <tr> <td>c.</td> <td>ANOXIC ENCEPHALOPATHY</td> <td>8 YEARS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. | SEPSIS | Approximate Interval Between Onset and Death
HOURS | b. | CHRONIC VEGETATIVE STATE | 8 YEARS | c. | ANOXIC ENCEPHALOPATHY | 8 YEARS | d. | |
| Immediate Cause (Final disease or condition resulting in death) | a. | SEPSIS | Approximate Interval Between Onset and Death
HOURS | | | | | | | | | | | | | | | | | | | |
| | b. | CHRONIC VEGETATIVE STATE | 8 YEARS | | | | | | | | | | | | | | | | | | | |
| | c. | ANOXIC ENCEPHALOPATHY | 8 YEARS | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Peter M. Schisler MD Attending MD | | | | 29c. License number
022780 | | 29d. Date signed (Month, Day, Year)
1/27/97 | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter M. Schisler MD 7500 Greenway Ctr Dr. Greenbelt, MD 20770 | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | 32. Registrar's Signature
[Signature] | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04197

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Patricia Elizabeth Burley | | | | 2. Date of Death
Month Day Year
January 22, 1997 | | 3. Time of Death
1:29 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Prince George's Hospital | | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
220-50-6341 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
51 Yrs. | | 8. Date of Birth (Month, Day, Year)
06-26-45 | |
| | 9. Birthplace (State or Foreign Country)
Washington DC | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Landover | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3320 Dodge Park Road | | 10f. Zip Code
20785 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 2+ College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nurses Aide | | 16b. Kind of Business/Industry
Private | | | |
| | 17. Father's Name (First, Middle, Last)
George Burley | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Butler | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Yolanda Soule/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1407 Beaver Heights Lane, Capitol Heights MD 20743 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Date
1/28/97 | | 20d. Location - City or Town, State
Beltsville, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Nancy A. Percantie | | | | 22. Name and Address of Facility
J.B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
AIDS.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Yrs. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
N. Vavakoli | | 29c. License number
D41978 | |
| | 29d. Date signed (Month, Day, Year)
1-24-97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. Vavakoli | | 30. Address
3001 Hospital Drive
Cheverly, MD 20785 | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | 32. Registrar's Signature
[Signature] | | | |
| | 33. Date of Death (Month, Day, Year)
January 22, 1997 | | | | 34. Time of Death
1:29 p.m. | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04 198

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | |
|---|--|---|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)
FRANK BORRELLO | | | 2. Date of Death
Month Day Year
January 25 1997 | | 3. Time of Death
7:06 pm | |
| 4a. Facility Name (If not institution, give street and number)
Prince George's Hospital Center | | | 4b. City, Town, or Location of Death
Cheverly | | 4c. County of Death
Prince George's | |
| 5. Social Security Number
118-01-3896 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Sept. 25, 1921 |
| Usual Residence of Decedent | | | 9. Birthplace (State or Foreign Country)
Connecticut | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Aquasco | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number
22411 Aquasco Road | | | 10f. Zip Code
20608 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1940-45 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Railway Express | |
| 17. Father's Name (First, Middle, Last)
Antonio Borrello | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rose Spadaro | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Frank A. Borrello - Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2706 Woodfern Court, Woodbridge, Virginia 22192 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Location - City or Town, State
01/28/97 Alexandria, Virginia | | |
| 21. Signature of Funeral Service Licensee
W.B. Goss | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. SEPSIS
Due to (or as a consequence of):
f. FUNGEMIA
Due to (or as a consequence of):
g. PULMONARY EDEMA
Due to (or as a consequence of):
h. CONGESTIVE HEART FAILURE | | | | | | Approximate Interval Between Onset and Death
3 WEEKS
2 1/2 WEEKS
2 1/2 WEEKS
2 1/2 WEEKS |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE
DIABETES MELLITUS
RENAL INSUFFICIENCY | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown

24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| 29b. Signature and title of certifier
Manbir Takhar M.D. | | 29c. License number
D46747 | | 29d. Date signed (Month, Day, Year)
01/26/1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MANBIR TAKHAR 9407 QUILL PLACE, GAITHERSBURG, MD 20879 | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10 IVa

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04199

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joseph Linwood Chester | | | | 2. Date of Death
Month February Day 01 Year 1997 | | 3. Time of Death
11:30 p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
701 Race Street Apt. 419 | | | | 4b. City, Town, or Location of Death
Cambridge | | 4c. County of Death
Dorchester | |
| Funeral
Director | 5. Social Security Number
213-42-1041 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
53 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 20, 1944 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Dorchester | | 10c. City, Town or Location
Cambridge | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
701 Race Street Apt. 419 | | 10f. Zip Code
21613 | | 10g. Citizen of What Country?
U.S. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Lift-Truck Driver | | 16b. Kind of Business/Industry
Packing Company | | | |
| | 17. Father's Name (First, Middle, Last)
Leon Murphy Chester | | 18. Mother's Name (First, Middle, Maiden Surname)
Irene Mary Meekins | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
ANN ASKINS (sister) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
416 Linden Ave, Cambridge, Maryland 21613 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meekins Neck Cemetery | | 20c. Date
2/8/97 | | 20d. Location - City or Town, State
Church Creek, MD. | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Janelle C. Henry | | 22. Name and Address of Facility
HENRY FUNERAL HOME
510 Washington St. Cambridge, MD. 21613 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Non-small cell lung carcinoma
Dua to (or as a consequence of):

b.
Dua to (or as a consequence of):

c.
Dua to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death
1 1/2 yrs. | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
David H Smith | | 29c. License number
039887 | | 29d. Date signed (Month, Day, Year)
2/3/97 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David H Smith 509 Idlewild Ave Easton md | | 31. Date filed (Month, Day, Year)
FEB 4 1997 | | | | | |
| | 32. Registrar's Signature
John Andrew Randall | | 33. State Registrar | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04200

Items: 19a,b per F.H.G-744 2/27/97 reb

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Milton Carlson

2. Date of Death

Jan 26, 1997

3. Time of Death

9:37 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

049-09-8558

6. Sex

XX 20

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sep 3, 1908

9. Birthplace (State or Foreign Country)

Conn.

Usual Residence of Decedent

10a. State

Ct.

10b. County

Middlesex

10c. City, Town or Location

East Haddam

10d. Inside City Limits

1X Yes 2 No

10e. Street and Number

50 Bailey Road

10f. Zip Code

06423

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Plant Manager

16b. Kind of Business/Industry

Aircraft
Manufacturing

17. Father's Name (First, Middle, Last)

Andrew John Carlson

18. Mother's Name (First, Middle, Maiden Surname)

Ida Theresa Fredell

19a. Permanent Name Relationship (Type, Print)

Mrs. Elin-Marie C. Papantones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

daugh. 6702 Geneva Lane Camp Spring, Maryland 20748

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)East Haddam Congregation
Church Cemetery

Date

Jan 31,
1997

20c. Location - City or Town, State

East Haddam, Ct.

21. Signature of Funeral Service Licensee

G. S. K.

22. Name and Address of Facility

Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, Maryland 2070723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

METABOLIC ACIDOSIS

2 wks

Due to (or as a consequence of):

b.

RENAL FAILURE

3 mos

Due to (or as a consequence of):

c.

RHABDO MYOLYSIS

1 mo

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL BLEEDING

23b. Did tobacco use contribute to the cause of death?

1 Yes 2X No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2X No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2X No

25. Was case referred to medical
examiner?

1 Yes 2X No

26. Place of Death (Check only one)

Hospital:

1X Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1X Natural 5 Pending
2 Accident investigation
3 Suicide 6 Could not be
4 Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. S. Searchand MD (Attending)

29c. License number

D29646

29d. Date signed (Month, Day, Year)

01, 27, 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. S. Searchand M.D. 3600 Leonardtown Rd, #103 Waldorf, MD 20601

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

John Searchand

State
Registrar

Baltimore, Maryland 21215-0020

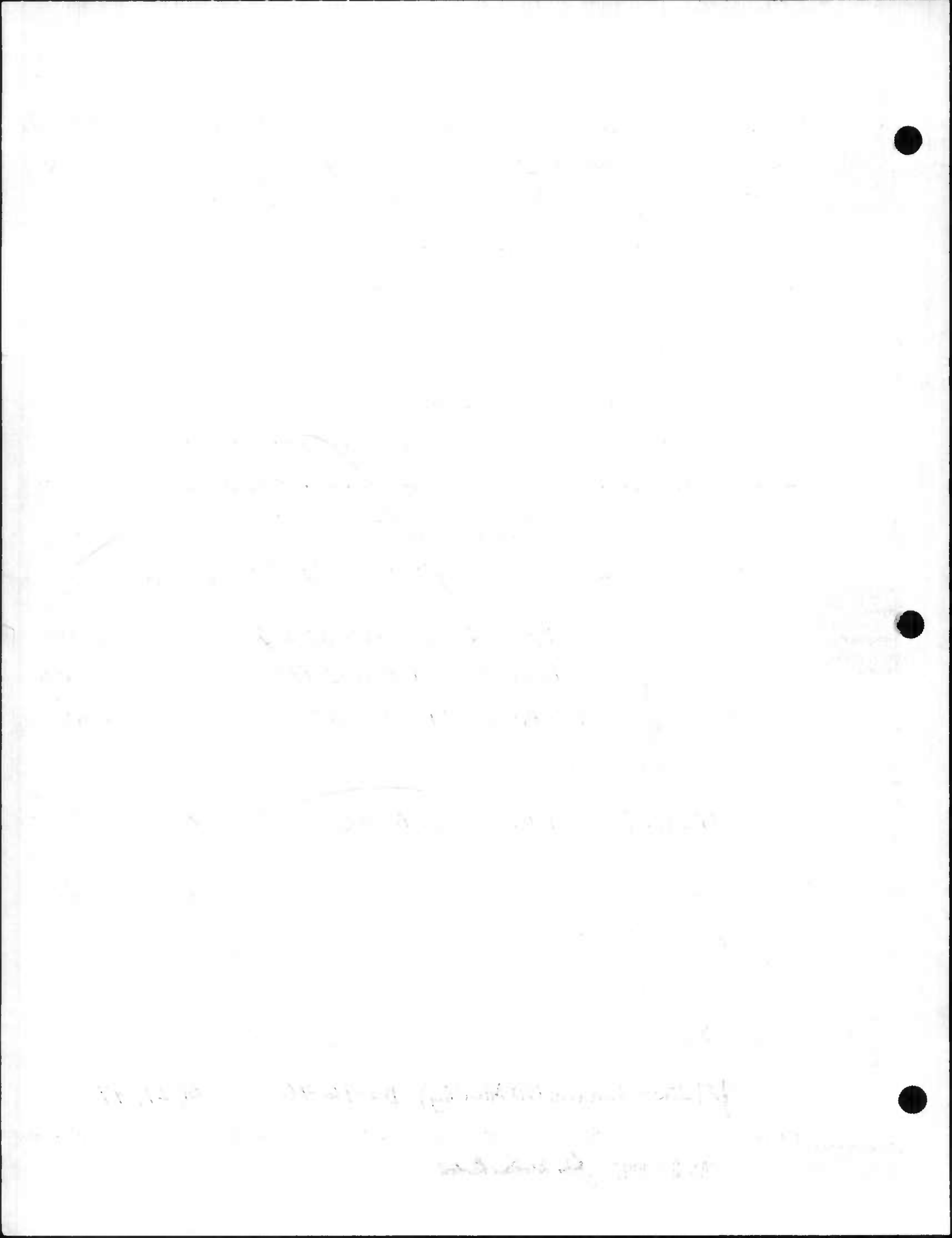
Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04201

Reg. No.

| | | | | | | | | | | | | | |
|--|---|--|--|---|---|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Francis Ellsworth Chipman | | | | | 2. Date of Death
Month JANUARY Day 26 Year 1997 | | 3. Time of Death
8:00PM | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | | | | |
| Funeral
Director | 5. Social Security Number
117-24-4575 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
64 Yrs. | | 8. Date of Birth (Month, Day, Year)
30-Dec-32 | | 9. Birthplace (State or Foreign Country)
Connecticut | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Allegany | | 10c. City, Town or Location
Frostburg | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10a. Street and Number
510 Grandview Drive | | | | | 10f. Zip Code
21532- | | 10g. Citizen of What Country?
U.S.A. | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Carpenter | | | 16b. Kind of Business/Industry
Construction | | | | | |
| 17. Father's Name (First, Middle, Last)
Albert Chipman | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Caroline Whitten | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jeanetta Chipman Wife | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
510 Grandview Drive Frostburg Maryland 21532- | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory | | Date
29-Jan-97 | | 20c. Location - City or Town, State
Cumberland, Maryland | | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 | | | | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death)


 Due to (or as a consequence of):
 a. Suppurative Vena Cava Syndrome - recurrent
 Due to (or as a consequence of):
 b. Squamous Cell Carcinoma of lung
 Due to (or as a consequence of):
 c. _____
 Due to (or as a consequence of):
 d. _____ </td> <td style="width:10%; text-align: center; vertical-align: middle; font-size: 4em;">}</td> <td style="width:60%; vertical-align: top;"> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

 e. _____
 f. _____
 g. _____
 h. _____ </td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
a. Suppurative Vena Cava Syndrome - recurrent
Due to (or as a consequence of):
b. Squamous Cell Carcinoma of lung
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | } | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. _____
f. _____
g. _____
h. _____ | |
| Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):
a. Suppurative Vena Cava Syndrome - recurrent
Due to (or as a consequence of):
b. Squamous Cell Carcinoma of lung
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | } | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. _____
f. _____
g. _____
h. _____ | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:70%;"> 23b. Did tobacco use contribute to the cause of death?
 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown </td> <td style="width:30%; vertical-align: top;"> 24a. Was an autopsy performed?
 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> <tr> <td colspan="2"> 24b. Were autopsy findings available prior to completion of cause of death?
 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> </tr> </table> | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Malignant pericarditis with Pericardial effusion
Total occlusion of the right Main Stem Artery
Right Subclavian Vein and Rt jugular Vein obstruction | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | 29b. Signature and title of certifier
 | | 29c. License number
D13601 | | 29d. Date signed (Month, Day, Year)
JANUARY 26 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
V. Paul Felipa M.D. 925 Bishop Wash Road, Cumberland, MD 21502 | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

**State
Registrar**

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04202

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ESTHER CUNNINGHAM

2. Date of Death

Month Day Year
JANUARY 27 1997

3. Time of Death

8:05 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

214-07-5656

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Aug 18, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1 Baltimore Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Former Employee

16b. Kind of Business/Industry

Textile

17. Father's Name (First, Middle, Last)

William Brown

18. Mother's Name (First, Middle, Maiden Surname)

Mary C. (Trapp)

19a. Informant's Name/Relationship (Type, Print)

Jean A Dorsey-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Carpendale, WV 26753

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

01/31

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home

Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. J. Poonai MD

29c. License number

D 36766

29d. Date signed (Month, Day, Year)

JAN 28, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIK POONAI M.D., 955 FREDERICK STREET, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

JAN 29 1997

32. Registrar's Signature

John A. Harkness

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04203

Reg. No.

**Physician
/Medical
Examiner**

1. Decedent's Name (First, Middle, Last)

Fred M Curto

2. Date of Death

Month Day Year
FEBRUARY 2, 1997

3. Time of Death

6:43 p

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

**Funeral
Director**

5. Social Security Number

132-28-6386

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 25 1939

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Rising Sun

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

152 Wilson Rd.

10f. Zip Code

21911

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: 1958

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Aerospace Mfg.

17. Father's Name (First, Middle, Last)

Fred B. Curto

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Culver

19a. Informant's Name/Relationship (Type, Print)

Timothy Curto/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

152 Wilson Rd. Rising Sun MD 21911

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Nottingham Cmty Feb 7 1997 Colora MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.

111 S Queen St. Rising Sun MD 21911

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Electrical Mechanical dissociation

Approximate Interval Between Onset and Death

2 hours.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Transplant

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Sanjeev Gulati MD

RES-000

February 2, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sanjeev Gulati Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

FEB 04 1997

32. Registrar's Signature

John A. Davidson-Randall

**State
Registrar**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician
/Medical
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

FEB 9 1981

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04204

Amended # 5. P.G.C. 2/10/97 cr

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|---|--|---|--|--|--|---|--|--|--|------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George Allen Chandler | | | | 2. Date of Death
Month January Day 22, Year 1997 | | 3. Time of Death
2:55 PM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Doctors Community Hospital | | | | 4b. City, Town, or Location of Death
Lanham | | 4c. County of Death
Prince Georges | | | | | | | |
| Funeral
Director | 5. Social Security Number
578-42-7278 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
63 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 9, 1933 | | 9. Birthplace (State or Foreign Country)
Washington, D.C. | | | | | |
| | Usual Residence of Decedent
10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Capital Heights 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
717 Opus Avenue | | 10f. Zip Code
20743 | | 10g. Citizen of What Country?
United States | | | | | |
| To Be Completed by Funeral Director | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Cab Driver | | 16b. Kind of Business/Industry
Self Employed | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Charles B. Chandler | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Amanda Brown | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Allen K. Chandler - Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
717 Opus Avenue, Capital Heights, Maryland 20743 | | | | | | | | | |
| Physician
/Medical
Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial Cemetery | | Data
1/27/97 | | 20c. Location - City or Town, State
Suitland, MD | | | | | | | |
| | 21. Signature of Funeral Service Licensee
John T. Stewart III | | 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N. E., Washington, D. C. | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Cardiovascular Failure
Due to (or as a consequence of):
b. Sepsis
Due to (or as a consequence of):
c. Pneumonia
Due to (or as a consequence of):
d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
14 hours
2 days
4 days | | | | | | | | Approximate Interval Between Onset and Death | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Hypertension
Obesity | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | 29b. Signature and title of certifier
no, ph.d. | | 29c. License number
46093 | | 29d. Date signed (Month, Day, Year)
1/23/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Roderic M. Stachura 7305 Hanover Parkway Greenbelt, MD 20770 | | | | | | | | 31. Data filed (Month, Day, Year)
JAN 28 1997 | | | | | |
| State Registrar | 32. Registrar's Signature
[Signature] | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04205

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Vernon L. Campbell

2. Date of Death
Month Day Year

1 24 97

3. Time of Death
5:20 P.M.

4a. Facility Name (If not institution, give street and number)

9304 Lancelot Road

4b. City, Town, or Location of Death
Fort Washington4c. County of Death
Prince George'sFuneral
Director5. Social Security Number
253-74-36976. Sex
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)
Yrs. 54If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
March 1, 19429. Birthplace (State or Foreign
Country)
Georgia

Usual Residence of Decedent

10a. State

10b. County

Maryland Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9304 Lancelot Road

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1966-7013. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

General Manager - A.A.F.E.S.

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

John Luke Campbell

18. Mother's Name (First, Middle, Maiden Surname)

Luvenia Freeman

19a. Informant's Name/Relationship (Type, Print)

Beulah K. Campbell/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9304 Lancelot Rd., Fort Washington, Md. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resurrection Cemetery

Date

1/29/97

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Robert P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e.

Cardiopulmonary Arrest

Due to (or as a consequence of):

b.

Hypertension

Due to (or as a consequence of):

c.

Obesity

Due to (or as a consequence of):

d.

Hypercholesterolemia

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. R. Edgewood MD

29c. License number

P23826

29d. Date signed (Month, Day, Year)

1-25-97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

G. R. Edgewood MD 7700 Old Branch Ave Clinton MD 20735

31. Date filed (Month, Day, Year)

JAN 27 1997

32. Registrar's Signature

John A. Harper-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04206

Certificate of Death

Reg. No.

| | | | | | |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANNIE COBBS | | 2. Date of Death
Month JANUARY Day 22 Year 1997 | | 3. Time of Death
8:21 AM |
| | 4e. Facility Name (If not institution, give street end number)
SOUTHEAN MARYLAND HOSPITAL | | 4b. City, Town, or Location of Death
CLINTON | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
251-36-2197 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
69 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
July 27, 1927 | | 9. Birthplace (State or Foreign Country)
Aiken, S.C. | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10e. State
Maryland | | 10b. County
Prince George's |
| | 10c. City, Town or Location
Temple Hills | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street end Number
2209 Jameson Street | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4or 5+) College | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
House Keeping | | 16b. Kind of Business/Industry
Private | | |
| | 17. Father's Name (First, Middle, Last)
Spy Gould | | 18. Mother's Name (First, Middle, Maiden Surname)
Fanny (Unknown) | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Charles E. Cobbs - Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2209 Jameson Street, Temple Hills, MD 20748 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
1/28/97 Brentwood, Maryland |
| | 21. Signature of Funeral Service Licensee
John T. Stewart III | | 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N. E., Washington, D. C. | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Hypotension & Bradycardia
Due to (or as a consequence of):
Coronary Artery Disease
Due to (or as a consequence of):
Hypertension Congestive Heart Failure
Due to (or as a consequence of):
Chronic Lung Disease | | | | Approximate Interval Between Onset and Death
1 hr
5 yr
5 yr |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28e. Date of Injury (Month, Day Year) | | 28b. Time of injury
M <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
MD Attending | | 29c. License number
D-24535 | | 29d. Date signed (Month, Day, Year)
1/22/97 |
| | 30. Name and address of person who completed cause of death (Item 25e) (Type, Print)
LUMI BERWA 7705 OGD BROAD AVE. CLINTON MD 20735 | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
JAN 28 1997 | | 32. Registrar's Signature
[Signature] | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 04207
Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KELLOP HENRY CARTWRIGHT, JR. | | | | 2. Date of Death
Month Day Year
January 24, 1997 | | 3. Time of Death
11:45 pm | |
| | 4a. Facility Name (If not institution, give street and number)
5000 Edmonston Road | | | | 4b. City, Town, or Location of Death
Hyattsville | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
577-36-5644 | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
67 Yrs. | 8. Under 1 Year
Months Days | 9. Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Jan. 12, 1930 | | 9. Birthplace (State or Foreign Country)
Virginia |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Prince George's | 10c. City, Town or Location
Hyattsville | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
5000 Edmonston Road | | | 10f. Zip Code
20781 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
House Painter | | | 16b. Kind of Business/Industry
Myers-Christiansen Co. | | |
| | 17. Father's Name (First, Middle, Last)
Kellop Henry Cartwright | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eunice Bowden | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Juanita B. Cartwright - Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5000 Edmonston Road, Hyattsville, Maryland 20781 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | Date
01/28/97 | | 20c. Location - City or Town, State
Brentwood, Maryland | |
| | 21. Signature of Funeral Service Licensee
<i>H. Constance Gasch</i> | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Respiratory failure 2° to Cancer of lung</i>
Due to (or as a consequence of):
b. <i>metastatic cancer of lung</i>
Due to (or as a consequence of):
c. <i>Brain tumor</i>
Due to (or as a consequence of):
d. <i>Chronic obstructive pulmonary dis.</i>
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death
10/96
10/96
1990 | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Hypertension</i>
<i>Diabetes mellitus</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | | | 29c. License number
D34722 | | 29d. Date signed (Month, Day, Year)
January 25, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Vicken Poochikian, M.D. 5632 Annapolis Road, Bladensburg, Maryland 20710-2213 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-698-0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04208

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|---|--------------------------|---|---|----------------------------------|--|--------------------|----------------|-------------------------------------|----------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Janey Elizabeth Campbell</i> | | | | 2. Date of Death
Month <i>January</i> Day <i>27</i> Year <i>1997</i> | | 3. Time of Death
<i>3:35 AM</i> | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Doctors Community Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Lanham</i> | | 4c. County of Death
<i>Prince Georges</i> | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
<i>230-30-9711</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>73</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>July 25, 1923</i> | 9. Birthplace (State or Foreign Country)
<i>Virginia</i> | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | | 10b. County
<i>Prince George's</i> | | 10c. City, Town or Location
<i>Adelphi</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| | 10e. Street and Number
<i>1801 Metzertott Road</i> | | | | 10f. Zip Code
<i>20783</i> | | 10g. Citizen of What Country?
<i>United States</i> | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Homemaker</i> | | 16b. Kind of Business/Industry
<i>Own Home</i> | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Napoleon Ashby Leach</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Emma Nora Mitchell</i> | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<i>Gerald E. Schlorb, Jr. - Son</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4404 40th St., Brentwood, Maryland 20722</i> | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Fort Lincoln Cemetery</i> | | Date
<i>1-30-97</i> | | 20c. Location - City or Town, State
<i>Brentwood, Maryland</i> | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Lisa S. Johnson</i> | | | | 22. Name and Address of Facility
<i>Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, Maryland 20722</i> | | | | | | | | | | | | | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Cardiac Arrest</i></td> <td>Approximate Interval Between Onset and Death
<i>30 minutes</i></td> </tr> <tr> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b. <i>Semicoma</i></td> <td><i>3 hours</i></td> </tr> <tr> <td>c. <i>Cerebro Vascular Accident</i></td> <td><i>11 days</i></td> </tr> <tr> <td>d. <i>Bilateral cerebral Artery occlusion</i></td> <td><i>3 years</i></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. <i>Cardiac Arrest</i> | Approximate Interval Between Onset and Death
<i>30 minutes</i> | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | | b. <i>Semicoma</i> | <i>3 hours</i> | c. <i>Cerebro Vascular Accident</i> | <i>11 days</i> | d. <i>Bilateral cerebral Artery occlusion</i> |
| Immediate Cause (Final disease or condition resulting in death) | a. <i>Cardiac Arrest</i> | Approximate Interval Between Onset and Death
<i>30 minutes</i> | | | | | | | | | | | | | | | | | |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | |
| | b. <i>Semicoma</i> | <i>3 hours</i> | | | | | | | | | | | | | | | | | |
| | c. <i>Cerebro Vascular Accident</i> | <i>11 days</i> | | | | | | | | | | | | | | | | | |
| | d. <i>Bilateral cerebral Artery occlusion</i> | <i>3 years</i> | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Coronary Artery Disease</i>
<i>Diabetes Poorly controlled</i>
<i>HYPERTENSION</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>221883</i> | | 29d. Date signed (Month, Day, Year)
<i>1/27/97</i> | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>HEMA P. YADLA M.D. 9470, ANNAPOLIS RD, Suite #308 LANHAM MD 20706</i> | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>JAN 30 1997</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04209

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clidel Edgar Davis SR.

2. Date of Death
Month Day Year

2/2/97

3. Time of Death

21:10

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral
Director

5. Social Security Number

219-14-4391

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

APR 108, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Salem

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Route 2 Box 4624

10f. Zip Code

21869

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FOREMAN

16b. Kind of Business/Industry

Canning Industry

17. Father's Name (First, Middle, Last)

Edgar Davis

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Nutter

19a. Informant's Name/Relationship (Type, Print)

Agnes Davis (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Route 2 Box 4624 Salem, Maryland 21869

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Pleasant Cemetery

Date

2/8/97 Salem, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janette C. Henry

22. Name and Address of Facility

HENRY FUNERAL HOME
510 Washington St. Cambridge, MD. 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Bowel Obstruction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ca of Bowel

Due to (or as a consequence of):

3 yrs

c. Rectosigmoid Ca

Due to (or as a consequence of):

15 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

2 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vinodrai Mehta attending physician

29c. License number

D 15541

29d. Date signed (Month, Day, Year)

2/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinodrai Mehta 400 Aurora St. Cambridge, MD. 21613

31. Date filed (Month, Day, Year)

FEB 4 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

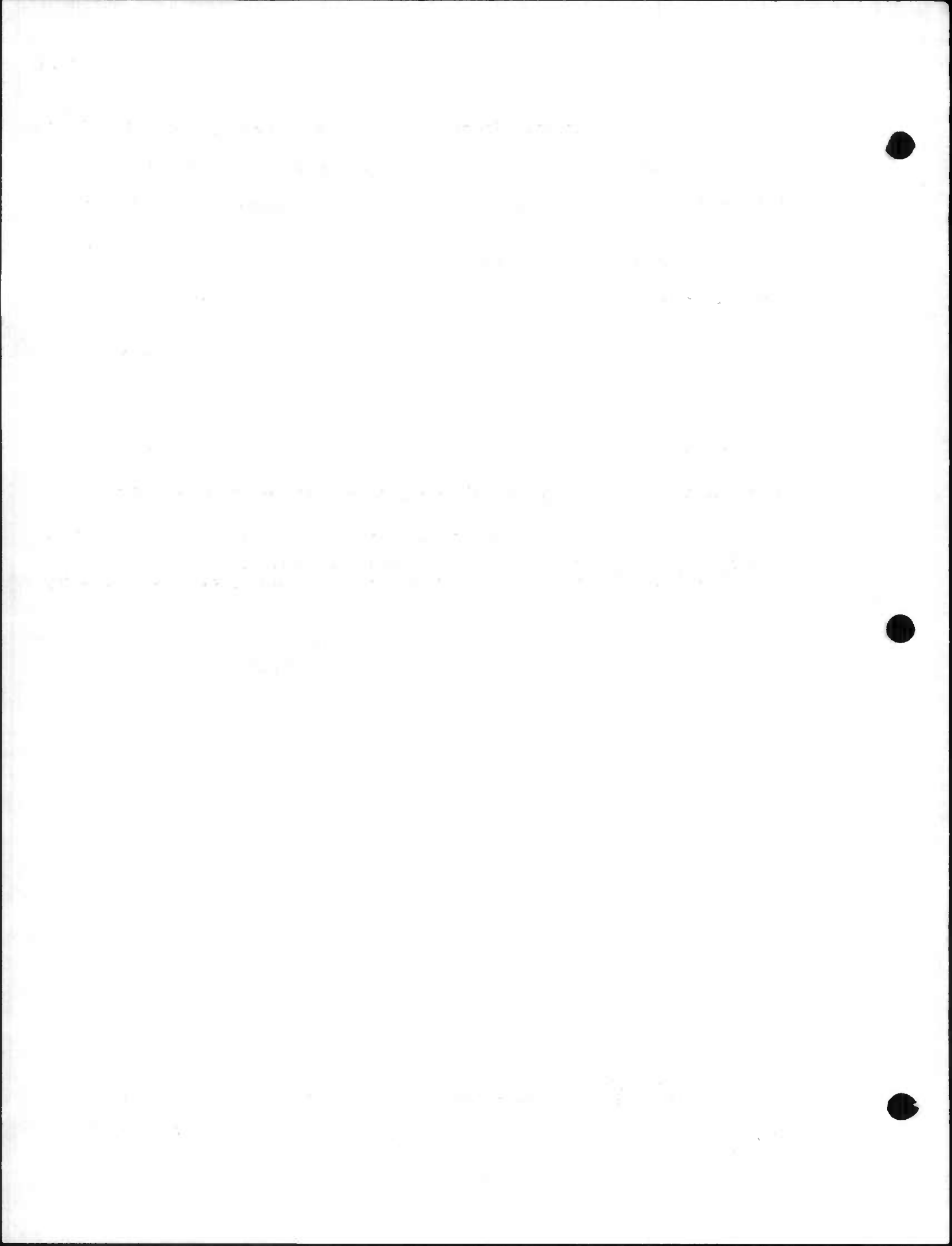
State of Maryland / Department of Health and Mental Hygiene

97 04210

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|---|--|---|---|--|--|--|--------------------------------------|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Elizabeth Ducat | | | | 2. Date of Death
Month January Day 24 Year 1997 | | 3. Time of Death
4:45 p.m. | | | |
| | 4a. Facility Name (If not institution, give street and number)
8105 Custer Road | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | | | |
| Funeral
Director | 5. Social Security Number
104-07-8085 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 07, 1908 | 9. Birthplace (State or Foreign Country)
New York | | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10a. Street and Number
8105 Custer Road | | | | 10f. Zip Code
20814 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Grade 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Educator | | 16b. Kind of Business/Industry
US Government | | | | |
| 17. Father's Name (First, Middle, Last)
John Baumann | | | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Diane Ducat daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
215 West 92nd St. #15, New York, NY 10025 | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Hope Cemetery | | Date
1/28/97 | | 20c. Location - City or Town, State
Rochester, New York | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707-4389 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cardiomyopathy
Due to (or as a consequence of):
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Renal Insufficiency
Generalized Arteriosclerosis
Hypertension | | | | | | | | Approximate Interval Between Onset and Death
1 year | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Insufficiency
Generalized Arteriosclerosis
Hypertension | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28g. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. Signature and title of certifier
<i>Wesley B. Mason M.D.</i> | 29c. License number
D22235 | 29d. Date signed (Month, Day, Year)
1/24/97 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Wesley B. Mason, 10810 Connecticut Ave, Kensington, Md., 20895 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 27 1997 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04211

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|-------------------------------|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
VULA BLANCH DICKEN | | | | | | 2. Date of Death
Month Day Year
JANUARY 26 1997 | | 3. Time of Death
3:10PM | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
216-74-5159 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
86 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 16 1910 | | 9. Birthplace (State or Foreign Country)
PETERSBURG, WVA | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
PENNA | | 10b. County
BEDFORD | | 10c. City, Town or Location
SOUTHAMPTON TOWNSHIP | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
RD 3 CLEARVILLE | | | | 10f. Zip Code
15535 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | | 16b. Kind of Business/Industry
OWN HOME | | | |
| 17. Father's Name (First, Middle, Last)
VAN B. RATCLIFF | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
VIRGINIA BELL RIGGLEMAN | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
MRS. JOYCE MILLER/DAUGHTER | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RD 2 CLEARVILLE, PENNA, 15535 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
PROSPERITY CEMETERY | | | Date
1-29-97 | | 20c. Location - City or Town, State
SOUTHAMPTON TWP PA | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | | | 22. Name and Address of Facility
DALLA VALLE FUNERAL SVC, INC PO BOX 179
EVERETT, PENNA, 15537 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Emphysema | | | | | | | | | | |
| 23b. Approximate Interval Between Onset and Death
3 years | | | | | | | | | | |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cor pulmonale | | | | | | | | | | |
| 23d. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day Year)
1-29-97 | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | 29b. Signature and title of certifier
<i>Richard G. Schmitt</i> | | | 29c. License number
D26333 | | 29d. Date signed (Month, Day, Year)
JANUARY 27 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard G. Schmitt 900 Seton Drive Cumberland, MD 21502 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | | | | | | | |
| 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04212

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LINDA CHRISTINE EDWARDS

2. Date of Death

Month Day Year
JANUARY 29 1997

3. Time of Death

8:03 AM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

220-58-1106

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 23 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

P.O. Box 1081 Redwood LA

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laundry Employee

16b. Kind of Business/Industry

RUS Uniform Co

17. Father's Name (First, Middle, Last)

George Alkire

16. Mother's Name (First, Middle, Maiden Surname)

Virginia L. (Hockaday)

19a. Informant's Name/Relationship (Type, Print)

Timothy Alkire-brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10003 Parkersburg RD, S Frostburg MD 21532

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

01/31

20c. Location - City or Town, State

Short Gap, WV

21. Signature of Funeral Service Licensee

Nicholas J. Scarpello

22. Name and Address of Funeral Home

Scarpello Funeral Home
Cumberland, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cervical Carcinoma

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

MALNUTRITION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ NoHospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how Injury occurred

26a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Welik

29c. License number

021875

29d. Date signed (Month, Day, Year)

JANUARY 29 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Welik 902 Seton Drive Cumberland MD 21502

31. Date filed (Month, Day, Year)

JAN 30 1997

32. Registrar's Signature

John D. Jackson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04213

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NELSON SAMUEL EVELAND

2. Date of Death

January 31, 1997

3. Time of Death

11:30AM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

182-18-7754

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 18, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Estes Lane

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Machinest

16b. Kind of Business/Industry

Airport

17. Father's Name (First, Middle, Last)

Daniel Eveland

18. Mother's Name (First, Middle, Maiden Surname)

Wortha Bullocks

19a. Informant's Name/Relationship (Type, Print)

Margaret A. Eveland/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Estes Lane, North East, MD 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens

Date

Feb 4 1997

20c. Location - City or Town, State

Aldino, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Endstage chronic obstructive pulmonary disease

10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40723

29d. Date signed (Month, Day, Year)

01/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARITHANOM ISAAC, M.D. Perry Point, Maryland 21902

31. Date filed (Month, Day, Year)

FEB 03 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

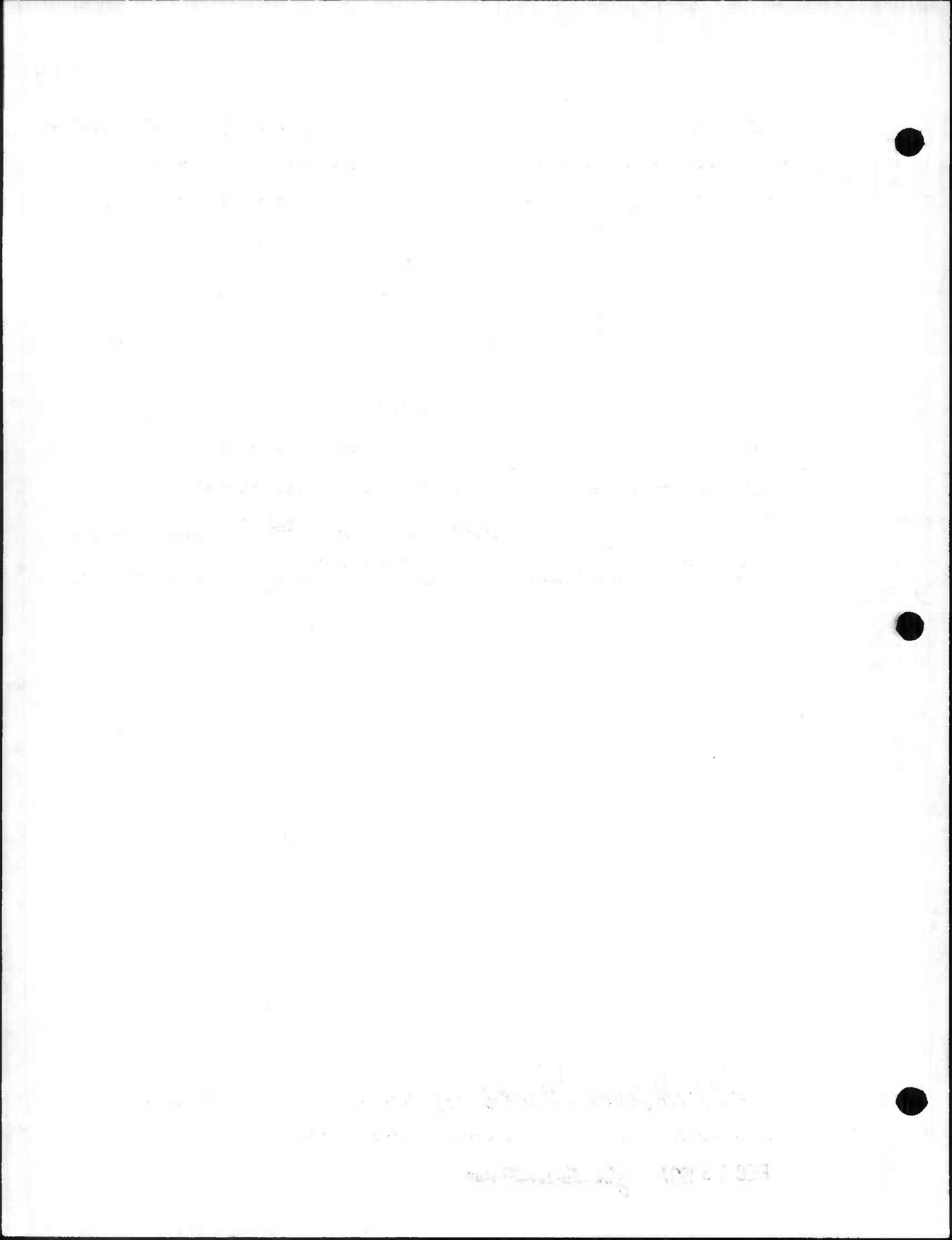
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04214

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALIENE C. EWELL | | | | 2. Date of Death
Month January Day 23 , Year 1997 | | 3. Time of Death
5:15 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Mariner of Bethesda | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
578-54-3061 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
100 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 18, 1896 | 9. Birthplace (State or Foreign Country)
Norfolk, VA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
5721 Grosvenor Lane | | | | 10f. Zip Code
20814 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 yrs. | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Registered Nurse | | 16b. Kind of Business/Industry
Freedmans Hospital | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Henry R. Carrington | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sallie Ann Clark | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Yvonne Smith Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1001 Spring Street, #704, Silver Spring, MD 20910 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial Cemetery | | 20c. Location - City or Town, State
1-30 Suitland, MD | | | |
| | 21. Signature of Funeral Service Licensee
J. P. Marshall | | | | 22. Name and Address of Facility
Marshall's Funeral Home, Inc.
4217 9th Street N.W., Washington, DC 20011 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia
Due to (or as a consequence of):
b. aspiration syndrome
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | Approximate Interval Between Onset and Death
days
months |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
multi-infarct dementia | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
David A. Blass MD | | 29c. License number
D23911 | | 29d. Date signed (Month, Day, Year)
January 24, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David A. Blass MD 9410 Old Georgetown Rd. Bethesda, Md. 20814 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 28 1997 | | 32. Registrar's Signature
John Marshall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

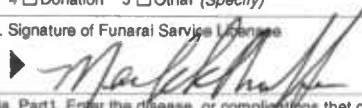
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

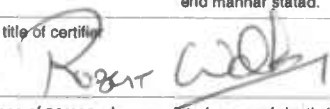
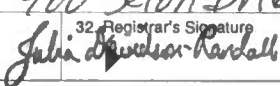
State of Maryland / Department of Health and Mental Hygiene

97 04215

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MANUS DARLINGTON FISHER | | | | 2. Date of Death
Month Day Year
JANUARY 29 1997 | | 3. Time of Death
10:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
SACRED HEART HOSPITAL | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
236-20-9264 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
74 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 4, 1922 | 9. Birthplace (State or Foreign Country)
West Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
WV | | 10b. County
HAMPSHIRE | | 10c. City, Town or Location
ROMNEY | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
68 EAST MAIN STREET | | | | 10f. Zip Code
26757 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1942-1945 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
MERCHANT | | | 16b. Kind of Business/Industry
HARDWARE STORE | |
| 17. Father's Name (First, Middle, Last)
Manus D. Fisher | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Leola Ruppenthal | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Robert R. Fisher, Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
68 East Main Street, Romney, WV 26757 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Omps Cremation Service | | Date
Jan 30 1997 | | 20c. Location - City or Town, State
Winchester, VA |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Shaffer Funeral Home, Inc.
230 East Main St., Romney, WV 26757 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOMYOPATHY
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
4 years
5 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
END STAGE RENAL DISEASE
Gout
Chronic | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D31875 | | 29d. Date signed (Month, Day, Year)
JANUARY 29, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Welik 900 Seton Drive Cumberland MD 21502 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 04 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04216

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
CHARLES Maynard FISHER | | | | 2. Date of Death
Month FEBRUARY Day 1 Year 1997 | | 3. Time of Death
19:50 | |
| 4a. Facility Name (If not institution, give street and number)
MEMORIAL HOSPITAL & MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| 5. Social Security Number
214-05-5172 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
February 9, 1918 | |
| 9. Birthplace (State or Foreign Country)
Maryland | | Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
10 N. Liberty Street, Apt. 201 | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 | | College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Machinist Helper | | 16b. Kind of Business/Industry
Railroad | |
| 17. Father's Name (First, Middle, Last)
Charles Walter Fisher | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Grove Rowe | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Marion Fisher/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 N. Liberty Street, Apt 201, Cumberland, Maryland 21502 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hillcrest Burial Park | | Date 1997 | | 20c. Location - City or Town, State
Cumberland, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Merritt-Adams Funeral Home
404 Decatur Street, Cumberland, Maryland 21502 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Stroke
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | Approximate Interval Between Onset and Death
2 weeks | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D 28910 | | 29d. Date signed (Month, Day, Year)
Feb 2, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. C.H. MERRICK, MEMORIAL HOSPITAL MEDICAL BUILDING, CUMBERLAND, MD 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 03 1997 | | 32. Registrar's Signature
 | | | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04217

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY MARGARET GRIM RUNION FIKE

2. Date of Death

Month Day Year
FEBRUARY 1, 1997

3. Time of Death

3:30 P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

214-07-3956

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Nov. 6, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

FROSTBURG

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

155 W. MAIN STREET

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (13-16)

Collage (14-16)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

DIRECTOR

16b. Kind of Business/Industry

PRE-SCHOOL

17. Father's Name (First, Middle, Last)

EDWIN S. GRIM

18. Mother's Name (First, Middle, Maiden Summa)

BESSIE BANNATYNE

19a. Informant's Name/Relationship (Type, Print)

GEORGE W. FIKE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

155 W. MAIN STREET - FROSTBURG, MD 21532

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

RESILAWN MEMORIAL GARDENS

Date

2/4/97

20c. Location - City or Town, State

LAVALLE, MD

21. Signature of Funeral Service Licensee

Handy N. Upchurch

22. Name and Address of Facility

GEORGE-UPCHURCH FUNERAL HOME, P.A.
202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of the Pancreas

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic ulcer - Stomach

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

FELIPA V. RAUL

29c. License number

D13601

29d. Date signed (Month, Day, Year)

FEBRUARY 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FELIPA V. RAUL, M.D. 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502

31. Date filed (Month, Day, Year)

FEB 03 1997

32. Registrar's Signature

John A. Buckner-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
ms

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04218

Items: 23 part I, 27 per MEO G-744 2/19/97 ^{re} Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HENRIETTA | | 2. Date of Death
Month JANUARY Day 20 Year 1997 | | 3. Time of Death
3:20 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
22910 AQUASCO ROAD | | 4b. City, Town, or Location of Death
AQUASCO | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
218-30-4761 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
June 18, 1928 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10e. State
Maryland | | 10b. County
Prince Georges |
| | 10c. City, Town or Location
Aquasco | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
22910 Aquasco Road | | 10f. Zip Code
20608 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker |
| | 17. Father's Name (First, Middle, Last)
Robert Douglas | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Douglas | | |
| | 19. Informant's Name/Relationship (Type, Print)
George Ford Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22615 Aquasco Road, Aquasco, Maryland 20608 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery | | 20c. Location - City or Town, State
Clinton, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Adams Funeral Home 20605 Aquasco Road, Aquasco Maryland 20608 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
e. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | |
| 28b. Time of Injury
M | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | | | | |
| 29c. License number
O.C.M.E. | | | | | |
| 29d. Date signed (Month, Day, Year)
JANUARY 21, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 PENN STREET BALTIMORE, MARYLAND 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 04 1997 | | | | | |
| 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04219

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE A. FORD | | | | 2. Date of Death
Month JANUARY Day 28 Year 1997 | | 3. Time of Death
07:55 AM FOUND | | |
| | 4a. Facility Name (If not institution, give street and number)
22910 ACQUASCO ROAD | | | | 4b. City, Town, or Location of Death
AQUASCO | | 4c. County of Death
PRINCE GEORGES | | |
| Funeral
Director | 5. Social Security Number
214-82-6056 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 9, 1912 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10. Usual Residence of Decedent
10a. State Maryland 10b. County Prince George's 10c. City, Town or Location Aquasco | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10e. Street and Number
22910 Aquasco Road | | 10f. Zip Code
20608 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Wood Cutter | | 16b. Kind of Business/Industry
Good Lumber Company | | | | | |
| 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice Ford | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mary Frances Young Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 26 Aquasco, Maryland 20608 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Church Cemetery | | 20c. Date
February 1, 1997 | | 20d. Location - City or Town, State
Bryantown, Maryland | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Adams Funeral Home 20605 Aquasco Road, Aquasco, Maryland 20608 | | | | | |
| 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death | |
| | | b. Due to (or as a consequence of): | | | | | | | |
| | | c. Due to (or as a consequence of): | | | | | | | |
| | | d. Due to (or as a consequence of): | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
DEPUTY MEDICAL EXAMINER | | 29d. Date signed (Month, Day, Year)
JANUARY 28, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARIO F. GOLLER JR. M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 04 1997 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04220

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STEPHEN THOMAS FLETCHER

2. Date of Death

January 26, 1997

3. Time of Death

0151a m

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

213-44-6903

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
03-25-1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3030-30th Street, S.E., Apt #307

10f. Zip Code

20020

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John V. I. Fletcher

18. Mother's Name (First, Middle, Maiden Surname)

Marie McLauria

19a. Informant's Name/Relationship (Type, Print)

Stephanie Fletcher/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5604 Davey Street, Capitol Heights, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ressurrection Cemetery

Date

02/01

1997

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentie

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

1-26-97

28b. Time of Injury

0130 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

pedestrian struck by Auto

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3072 30th St S.E. D.C.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R. Fowler

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David R. Fowler 111 PENN STREET, BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

JAN 29 1997

32. Registrar's Signature

David R. Fowler

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

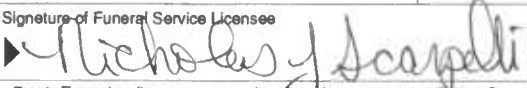
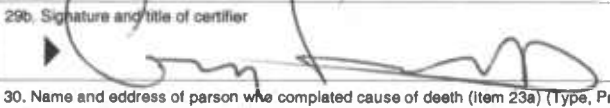
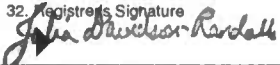
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04221

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|--|---------------------------------|--|---|---|--|--|--|---|----------------------------|---------|--|-----------------------------------|--------|-------------------------------------|--------|----|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Albert L. Grebenstein | | | | | | 2. Date of Death
Month Jan 25, Day 1997 Year | | 3. Time of Death
4:02 pm | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Memorial Hospital | | | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
214-36-6482 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
57 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 16, 1939 | | 9. Birthplace (State or Foreign Country)
MD | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| | 10e. Street and Number
514 Williams Street | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1957-59 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collegia (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Retired | | | 16b. Kind of Business/Industry
Tire Co. | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Karl Grebenstein | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alvera (Becker) | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Linda Grebenstein-wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
514 Williams Street Cumberland MD 21502 | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Cem | | 20c. Date
01/28 | | 20d. Location - City or Town, State
Flintstone, MD | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Acute Arrhythmia</td> <td>Seconds</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Coronary Artery Disease</td> <td>20 yrs</td> </tr> <tr> <td>c. Coronary Vascular Disease</td> <td>20 yrs</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. Acute Arrhythmia | Seconds | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Coronary Artery Disease | 20 yrs | c. Coronary Vascular Disease | 20 yrs | d. |
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Arrhythmia | Seconds | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Coronary Artery Disease | 20 yrs | | | | | | | | | | | | | | | | | |
| | c. Coronary Vascular Disease | 20 yrs | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | |
| 29. Certifier
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | | 29c. License number
D 12779 | | 29d. Date signed (Month, Day, Year)
Jan. 30, 1997 | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Fiscus Memorial Hsp Medical Bldg Cumberland MD 21502 | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 31 1997 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research. It also mentions the scope of the study and the limitations of the research.

2. The second part of the report is a literature review. It discusses the previous studies on the subject and identifies the gaps in the existing knowledge.

3. The third part of the report is the methodology. It describes the research design, the data collection methods, and the data analysis techniques.

4. The fourth part of the report is the results. It presents the findings of the study and discusses the implications of the results.

5. The fifth part of the report is the conclusion. It summarizes the main findings of the study and provides recommendations for future research.

6. The sixth part of the report is the references. It lists the sources of information used in the study.

7. The seventh part of the report is the appendix. It contains supplementary material that is not included in the main body of the report.

8. The eighth part of the report is the index. It provides a list of the topics covered in the report and the page numbers where they can be found.

9. The ninth part of the report is the bibliography. It lists the sources of information used in the study.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04222

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT L. GREEN

2. Date of Death
Month Day Year

JAN - 28, 1997

3. Time of Death

6:40 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

255-16-1125

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Feb. 25, 1912

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Adelphi

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1801 Metzertott Road

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

2

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Jesse Green

18. Mother's Name (First, Middle, Maiden Surname)

Sally Kegler

19a. Informant's Name/Relationship (Type, Print)

Lillie Green

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

852 21st. St., N.E., #4, Washington, D.C., 20002

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National Cem. 2/3/97

Date

20c. Location - City or Town, State

Triangle, Va.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Frazier Funeral Home, Inc.

389 Rhode Island Av., NW, Washington, D.C. 20001

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicidal ☐ Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of



29c. License number

D33942

29d. Date signed (Month, Day, Year)

1/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRAMOD DUGGAL, MD WASH.

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04223

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Mary Griffin</i> | | | | 2. Date of Death
Month <i>January</i> Day <i>25</i> Year <i>1997</i> | | | | 3. Time of Death
<i>10:15 am</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Prince George's Hospital Center</i> | | | | 4b. City, Town, or Location of Death
<i>Cheverly</i> | | | | 4c. County of Death
<i>Prince George's</i> | |
| Funeral
Director | 5. Social Security Number
<i>216-50-5942</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>52</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>03 07 1944</i> | | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | | 10b. County
<i>Prince George's</i> | | 10c. City, Town or Location
<i>Laurel</i> | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
<i>11710 South Laurel Drive</i> | | | | 10f. Zip Code
<i>20708</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>Housewife</i> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Housewife</i> | | 16b. Kind of Business/Industry
<i>Private</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Claudius Chisley</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Ada Foote</i> | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>James H. Griffin/Husband</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>11710 South Laurel Drive, Laurel, Maryland 20708</i> | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Harmony Memorial Park</i> | | Date
<i>01/31 1997</i> | | 20c. Location - City or Town, State
<i>Landover, Maryland</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>Nancy A. Perentis</i> | | | | 22. Name and Address of Facility
<i>J. B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785</i> | | | | | |
| | 23a. Per I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. <i>Cardiopulmonary Arrest</i>
Due to (or as a consequence of):
b. <i>Cellulitis Right leg</i>
Due to (or as a consequence of):
c. <i>Hypertension</i>
Due to (or as a consequence of):
d. <i>Morbid Obesity</i> | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Gregory J. Mc...</i> | | 29c. License number
<i>D30111</i> | | 29d. Date signed (Month, Day, Year)
<i>January 25, 1997</i> | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>11305 Aberdeen BELTSVILLE Md. 20705-1757</i> | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>JAN 31 1997</i> | | | | | | | | | | |
| 32. Registrar's Signature
<i>John M. ...</i> | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04224

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
RICHARD H. GREEN JR. | | | | 2. Date of Death
Month Day Year
JANUARY 24, 1997 | | 3. Time of Death
0122 | |
| | 4a. Facility Name (If not institution, give street and number)
Calvert Memorial Hospital | | | | 4b. City, Town, or Location of Death
Prince Frederick | | 4c. County of Death
Calvert | |
| Funeral
Director | 5. Social Security Number
577-50-0298 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 5, 1935 | |
| | 9. Birthplace (State or Foreign Country)
Washington, DC | | 10a. State
MD | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Deale | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
6179 Knopp Road | | 10f. Zip Code
20751 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (14 or 5+)
12 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Manager | | 16b. Kind of Business/Industry
General Glass Co. | | | |
| | 17. Father's Name (First, Middle, Last)
Richard H. Green, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Edna Claypool | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Joyce F. Green - Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6179 Knopp Road, Deale, Maryland 20751 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
Brentwood, Maryland | | 20d. Date
01/27/97 | |
| | 21. Signature of Funeral Service Licensee
W.B. Genser | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial infarction
Due to (or as a consequence of):
b. Diabetes
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Mark J. Kushner M.D. | | | | 29c. License number
D23468 | | 29d. Date signed (Month, Day, Year)
1/24/97 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Mark Kushner, M.D., Prince Frederick, MD 20678 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | 32. Registrar's Signature
[Signature] | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04225

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|--------------------------------|---|---|--|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jeanne McGiehan Gerdes | | | | 2. Date of Death
Month Day Year
January 24, 1997 | | 3. Time of Death
8:45 am | | | | |
| | 4e. Facility Name (If not institution, give street and number)
Mariner Health Care | | | | 4b. City, Town, or Location of Death
Laurel | | 4c. County of Death
Prince George's | | | | |
| Funeral
Director | 5. Social Security Number
438-01-9337 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 13, 1916 | | 9. Birthplace (State or Foreign Country)
Louisiana | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Bladensburg | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number
5800 Annapolis Road #402 | | | | 10f. Zip Code
20710 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | 16b. Kind of Business/Industry
Own Home | | | | |
| 17. Father's Name (First, Middle, Last)
Theodore Howard McGiehan | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Irene Jeanne Goldman | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Jeanne G. Weber - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5443 Varnum Street, Bladensburg, Maryland 20710 | | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery | | 20c. Location - City or Town, State
Arlington, Virginia | | 20d. Date
01/31/97 | | | |
| 21. Signature of Funeral Service Licensee
H. Constance Gasch | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. METASTATIC BRONCHIAL CELL CARCINOMA
Due to (or as a consequence of):
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Neil A. Meade, M.D. | | | | 29c. License number
019220 | | 29d. Date signed (Month, Day, Year)
January 27, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Neil A. Meade, M.D. 9811 Mallard Drive, Laurel, Maryland 20708-3179 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | 32. Registrar's Signature
[Signature] | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 20b 2-28-97 Film G744 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

97 04226

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALBERT GROSS | | | | 2. Date of Death
Month JANUARY Day 28 Year 1997 | | 3. Time of Death
01:14 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
218-16-0755 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
20 DEC 23 | |
| | 9. Birthplace (State or Foreign Country)
HYATTSVILLE MD. | | 10a. State
MD. | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
N. BRENTWOOD HYATTSVILLE MD. | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3932 allison st | | 10f. Zip Code
20722 | | 10g. Citizen of What Country?
U.S.A | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: 8/31/43 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8TH College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
TRUCK DRIVER | | 16b. Kind of Business/Industry
TRANSPORTATION | | | |
| | 17. Father's Name (First, Middle, Last)
GRANLEY GROSS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
MARY JOHNSON | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
MILDRED GROSS/WIFE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3932 ALLISON ST BRENTWOOD MD. HYATTSVILLE 20722 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHELTENHEM VETERANS CEM. | | 20c. Location - City or Town, State
2/4/97 CHELTENHEM MD. | | 21. Signature of Funeral Service Licensee
Leander M. Coles | |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility
TRI-STATE F.S. 6234 3rd ST NW WASH DC. 20011 | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CHRONIC EMPHYSEMA | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)
28 JAN 1997 | | | | 28b. Time of Injury
M | | | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred
3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
DEPUTY MEDICAL EXAMINER D 33954 | | | |
| | 29c. License number
D 33954 | | | | 29d. Date signed (Month, Day, Year)
JANUARY 28, 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARIO F. GOLIE JR. M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 | | | | 31. Data filed (Month, Day, Year)
JAN 30 1997 | | | |
| | 32. Registrar's Signature
John H. H. H. H. | | | | 33. Registrar's Title
Registrar | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04227

Reg. No.

| | | | | | | | | |
|---|--|--|--|---|--|---------------------------------|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LULA GREEN | | | | 2. Date of Death
Month Day Year
January 23, 1997 | | 3. Time of Death
7:20 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Mariner of Bethesda | | | | 4b. City, Town, or Location of Death
Bethesda | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
116-18-0294 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 4, 1917 | |
| | 9. Birthplace (State or Foreign Country)
Richmond, VA | | 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Bethesda | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
5721 Grosvenor Lane | | 10f. Zip Code
20814 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Elevator Operator | | 16b. Kind of Business/Industry
Census Bureau | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Teresa Brown Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8904 Copenhaver Dr., Potomac, MD 20854 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glenwood Cemetery | | 20c. Location - City or Town, State
1-31-97 Washington, DC | |
| | 21. Signature of Funeral Service Licensee
<i>J. P. Marshall</i> | | | | 22. Name and Address of Facility
Marshall's Funeral Home, Inc.
4217 9th Street N.W., Wash DC 20011 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>sepsis</i>
b. <i>pneumonia</i>
c. <i>aspiration syndrome</i>
d. | | | | Approximate Interval Between Onset and Death

<i>hours</i>

<i>days</i>

<i>months</i> | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>multi-infarct dementia</i> | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of injury (Month, Day Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
<i>David A. Blass MD</i> | | | | |
| 29c. License number
D23911 | | | | 29d. Date signed (Month, Day, Year)
January 24, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David A. Blass MD 9410 Old Georgetown Rd. Bethesda Md. 20814 | | | | 31. Date filed (Month, Day, Year)
JAN 30 1997 | | | | |
| 32. Registrar's Signature
<i>David A. Blass</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04228

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY E. HUNLEY

2. Date of Death

Month
JANDay
23Year
1997

3. Time of Death

2 AM

4a. Facility Name (If not Institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

425-52-9901

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan 23, 1997

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Jessup

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8242 Wellington Place

10f. Zip Code

20794

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 Years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Material Coordinator

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Jerry Hunley

spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8242 Wellington Place, Jessup, Maryland 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Columbia Memorial Park

Date

1/25/97

20c. Location - City or Town, State

Columbia, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. BACTERIAL SEPTICEMIA

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

4 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC KIDNEY FAILURE

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

René L. Gelsner MD

29c. License number

D 17502

29d. Date signed (Month, Day, Year)

1/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RENE L. GELSNER MD 10802 HICKORY RIDGE RD

COLUMBIA MD
21044

31. Date filed (Month, Day, Year)

JAN 27 1997

Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
15

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04229

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
William Claudie Hall | | 2. Date of Death
Month Day Year
January 28, 1997 | | 3. Time of Death
3:00 am |
| | 4a. Facility Name (If not institution, give street and number)
8212 Harvest Bend Lane #28 | | 4b. City, Town, or Location of Death
Laurel | | 4c. County of Death
Prince George |
| Funeral
Director | 5. Social Security Number
218-07-0909 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Nov 28, 1914 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
MD | 10b. County
Prince George | 10c. City, Town or Location
Laurel | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
8212 Harvest Bend Lane #28 | | 10f. Zip Code
20707 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Grade 7 College (1-4 or 5+) | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Supply Specialist | | 16b. Kind of Business/Industry
US Government | | |
| | 17. Father's Name (First, Middle, Last)
Richard Claudie Hall | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Mae Ireland | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Margaret A. Hall sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8212 Harvest Bend Lane, Laurel, Maryland 20707 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
1/31/97 Brentwood, Maryland |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707-4389 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | Approximate interval Between Onset and Death
minutes |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive lung disease | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| State Registrar | 29b. Signature and title of certifier
 | | 29c. License number
D13416 | | 29d. Date signed (Month, Day, Year)
January 28, 1997 |
| | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
William A. Warren, M.D. 321 Prince George Street, Laurel, Maryland 20707 | | | | |
| | 31. Date filed (Month, Day, Year)
JAN 31 1997 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part is a literature review, which summarizes the work of other researchers in the field. The third part is a description of the methodology used in the study. The fourth part is a presentation of the results of the study. The fifth part is a discussion of the results and their implications. The sixth part is a conclusion and a list of references.

2. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part is a literature review, which summarizes the work of other researchers in the field. The third part is a description of the methodology used in the study. The fourth part is a presentation of the results of the study. The fifth part is a discussion of the results and their implications. The sixth part is a conclusion and a list of references.

3. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part is a literature review, which summarizes the work of other researchers in the field. The third part is a description of the methodology used in the study. The fourth part is a presentation of the results of the study. The fifth part is a discussion of the results and their implications. The sixth part is a conclusion and a list of references.

4. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part is a literature review, which summarizes the work of other researchers in the field. The third part is a description of the methodology used in the study. The fourth part is a presentation of the results of the study. The fifth part is a discussion of the results and their implications. The sixth part is a conclusion and a list of references.

5. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part is a literature review, which summarizes the work of other researchers in the field. The third part is a description of the methodology used in the study. The fourth part is a presentation of the results of the study. The fifth part is a discussion of the results and their implications. The sixth part is a conclusion and a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04230

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) BEVERLY Virginia HUFF
2. Date of Death Month Day Year January 28, 1997
3. Time of Death 1:05 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number) Memorial Hospital
4b. City, Town, or Location of Death Cumberland
4c. County of Death Allegany

5. Social Security Number 220-10-4185
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 76 Yrs.
8. Date of Birth (Month, Day, Year) August 3, 1920
9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent
10a. State Maryland
10b. County Allegany
10c. City, Town or Location Cumberland
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 1411 Bedford Street
10f. Zip Code 21502
10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Textile worker
16b. Kind of Business/Industry yarn & Fabric

17. Father's Name (First, Middle, Last) Harry Edgar Mowery
18. Mother's Name (First, Middle, Maiden Surname) Thelma Combs

19a. Informant's Name/Relationship (Type, Print) EARL R. HUFF, Sr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Bedford St. Cumberland, Md. 21502

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Vet. Cemetery
20c. Location - City or Town, State Cumberland, Md.

21. Signature of Funeral Service Licensee Ernest A. Riley, Jr.
22. Name and Address of Facility Leisurestein, Inc. 230 Baltimore Avenue Cumberland, Md. 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
23b. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): 5 Days

b. Dementia Due to (or as a consequence of): 5 Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier William Lamm
29c. License number D 25406
29d. Date signed (Month, Day, Year) January 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William Lamm, 47 Virginia Ave., Cumberland, MD 21502

31. Date filed (Month, Day, Year) JAN 31 1997
32. Registrar's Signature John Davidson-Randall

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 6, per F.H. G-747 5/23/97 reb

Certificate of Death

Reg. No.

97 04231

| | | | | | | | | | | |
|---|---|--|---|--|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEONA MAE HUNT | | | | | | 2. Date of Death
Month Day Year
JAN 30 1997 | | 3. Time of Death
12:15 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
LIONS MANOR NURSING HOME | | | | | | 4b. City, Town, or Location of Death
CUMBERLAND | | 4c. County of Death
ALLEGANY | |
| Funeral
Director | 5. Social Security Number
218 50 0488 | | 6. Sex
15 M 20 F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 3, 1912 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
ALLEGANY | | 10c. City, Town or Location
FROSTBURG | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
19405 LOWER CONSOL ROAD, NW | | | | 10f. Zip Code
21532 | | 10g. Citizen of What Country?
U.S. | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEWIFE | | | 16b. Kind of Business/Industry
OWN HOME | | |
| | 17. Father's Name (First, Middle, Last)
GEORGE DONIUS | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROSE PORTER | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
ROBERT V. HUNT/ SON | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16304 CALLA HILL, MT. SAVAGE, MD 21545 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SUNSET MEMORIAL PARK | | Date
2/1/97 | | 20c. Location - City or Town, State
CUMBERLAND, MD 21502 | | |
| | 21. Signature of Funeral Service Licensee
<i>Monika M. Sowers</i> | | | | | 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A.
60 W. MAIN ST., FROSTBURG, MD 21532 | | | | |
| | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death)
e. <i>Congestive Heart failure - Pulm. edema 1 week</i>
Due to (or as a consequence of): | | | | | | | | |
| b. <i>Severe Anemia</i>
Due to (or as a consequence of): | | | | | | | | | | |
| c. <i>Endometrial carcinoma</i>
Due to (or as a consequence of): | | | | | | | | | | |
| d. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Senile dementia, hypertension</i> | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| | 29b. Signature and title of certifier
<i>V.A. Ranjithan</i> | | | | | 29c. License number
D19750 | | 29d. Date signed (Month, Day, Year)
Jan. 31 st , 1997. | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
V.A. Ranjithan, M.D., Lions Manor N.H., Seton Dr. Ext., Cumberland, MD 21502 | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 03 1997 | | 32. Registrar's Signature
<i>John W. Randall</i> | | | | | | | |
| | State Registrar | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4
ms

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04232

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Moodie Hamilton

2. Date of Death

February 1, 1997

3. Time of Death

9:45a.m.

4a. Facility Name (If not institution, give street and number)

16206 Livingston Rd.

4b. City, Town, or Location of Death

Accokeek

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

577-24-5682

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 25, 1912 Washington

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland Prince George Accokeek

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16206 Livingston Rd.

10f. Zip Code

20607

10g. Citizen of What Country?

U.S.A.

11. Marital Status:

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
216a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Charles Richard Hamilton

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Bickerton

19a. Informant's Name/Relationship (Type, Print)

Rebecca Cecil Granddaughter 4475 Shannon Way, Port Republic, Md.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20676

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

February 3, 1997

20c. Location - City or Town, State

Metropolitan Funeral Service Alexandria, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Williams Funeral Home, P.A.

M00668 4270 Hawthorne Rd., Indian Head, Md. 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or head failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. colon cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35206

29d. Date signed (Month, Day, Year)

Feb. 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William T. TANNER M.D. 11701 Livingston Road, Fort Washington, Md.

31. Date filed (Month, Day, Year)

FEB 04 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04233

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Lee Hall

2. Date of Death

January 29, 1997 8:22pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

9240 Parkway Subdivision Road

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

5. Social Security Number

218-38-6645

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUGUST 30, 1942 MARYLAND

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

1□ Yes 2X No

10e. Street and Number

9240 PARKWAY SUBDIVISION ROAD

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2X Married
3□ Widowed 4□ Divorced

12. Was Decedent Ever In U.S.

1□ Yes 2X No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1□ Yes 2X No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

17. Father's Name (First, Middle, Last)

WILLIAM JENNINGS HALL

18. Mother's Name (First, Middle, Maiden Surname)

MARIANNA AGNES TIPPETT

19a. Informant's Name/Relationship (Type, Print)

JANICE CHARLOTTE HALL / SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9240 PARKWAY SUBDIVISION ROAD
LA PLATA, MARYLAND 20646

20a. Method of Disposition

1X Burial 2□ Cremation 3□ Removal from State
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

TRINITY MEMORIAL GARDENS

Date

1FEB1997

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

JOHN P. KNISLEY

A-00719

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.

P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANCER OF LUNG

Due to (or as a consequence of):

b. BRAIN METS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 mo.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4X Unknown

24e. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

26. Place of Death (Check only one)

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5X Residence

6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending investigation
2□ Accident 6□ Could not be determined
3□ Suicide
4□ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. Knisley M. Mow

29c. License number

D28352

29d. Date signed (Month, Day, Year)

1/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Box 2729 LaPlata Md. 20646

31. Date filed (Month, Day, Year)

FEB 04 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

2. The second part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

3. The third part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

4. The fourth part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

5. The fifth part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

6. The sixth part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

7. The seventh part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

8. The eighth part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

9. The ninth part of the document is a list of names and dates. The names are: John Doe, Jane Smith, and Bob Johnson. The dates are: 1990, 1991, and 1992.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04234

Item #5 per FH G756 2/17/98 EW

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JAMES P. HAIDET | | 2. Date of Death
Month JAN. Day 28, Year 1997 | | 3. Time of Death
0635 AM |
| | 4a. Facility Name (If not institution, give street and number)
6900 BLK. OLD CHAPEL ROAD ROUTE#197 | | 4b. City, Town, or Location of Death
BOWIE | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
295 72 6222 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
32 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
June 14, 1964 | | 9. Birthplace (State or Foreign Country)
Ohio | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10a. State
Maryland | 10b. County
Prince George's | Bowie | | |
| | 10e. Street and Number
3910 Winchester Lane | | 10f. Zip Code
20715 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Computer Specialist |
| | 17. Father's Name (First, Middle, Last)
Francis R. Haidet | | 18. Mother's Name (First, Middle, Maiden Surname)
Eleanor M. Berger | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Nadine M. Haidet Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3910 Winchester Lane Bowie Maryland 20715 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Highland Memorial Cemetery | | 20c. Location - City or Town, State
2/3/97 Alliance Ohio |
| | 21. Signature of Funeral Service Licensee
Robert E. Evans, Pres | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Md. 20715 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
1-28-97 | | 28b. Time of Injury
0630 M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Pedestrian struck by Auto | | | |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
Roadway | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
6900 BLK RT 197 | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
[Signature] | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
JAN. 28, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 31 1997 | | 32. Registrar's Signature
[Signature] | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

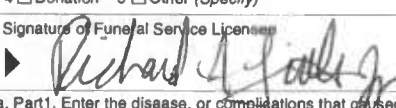
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

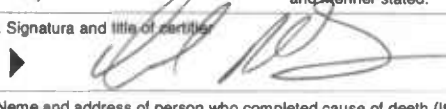
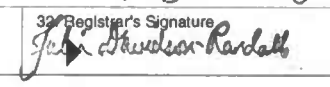
State of Maryland / Department of Health and Mental Hygiene

97 04235

Certificate of Death

Reg. No.

| | | | | | |
|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDNA F. HARMAN | | 2. Date of Death
Month FEBRUARY Day 7 Year 1997 | | 3. Time of Death
10:55AM |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
170 - 24-2079 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
April 24, 1910 | | 9. Birthplace (State or Foreign Country)
PA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
Carroll |
| | 10c. City, Town or Location
Westminster | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
4798 Arters Mill Rd. | | 10f. Zip Code
21157 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16. Kind of Business/Industry
House work |
| | 17. Father's Name (First, Middle, Last)
John Moose | | 18. Mother's Name (First, Middle, Maiden Surname)
Cora Myers | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Samuel L. Harman/Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
275 Matthias Rd. Littlestown, PA 17340 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Carmel Cemetery | | 20c. Location - City or Town, State
2/10/97 Littlestown, PA |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Little's F.H. 34 Maple Ave. Littlestown, PA 17340 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardio Pul arrest
Due to (or as a consequence of):
b. Sequelae + Valvular Heart Pain
Due to (or as a consequence of):
c. Stroke
Due to (or as a consequence of):
d. | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PUD
ASMD
Gangrene | | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | |
| | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how Injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D 40121 | | 29d. Date signed (Month, Day, Year)
2/17/97 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Buchbinder MD G Bmc | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04236

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lillian B. Harris | | | | 2. Date of Death
Month Day Year
January 8, 1997 | | 3. Time of Death
2:00 A.M. | | | |
| | 4e. Facility Name (If not institution, give street and number)
WASHINGTON ADVENTIST HOSPITAL | | | | 4b. City, Town, or Location of Death
TAKOMA PARK | | 4c. County of Death
MONTGOMERY | | | |
| Funeral
Director | 5. Social Security Number
235-26-1666 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 2, 1912 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | |
| | Usual Residence of Decedent | | | | 10e. State
10b. County
WASHINGTON, D.C. | | 10c. City, Town or Location
WASHINGTON, D.C. | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
USSAH #703, 3700 NORTH CAPITOL STREET, N.W. | | | | 10f. Zip Code
20317 | | 10g. Citizen of What Country?
UNITED STATES | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| To Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 Collega (1-4 or 5+) 12 | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWNED HOME | | | |
| | 17. Father's Name (First, Middle, Last)
JOHN GRAY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ROXIE THOMPSON | | | | | |
| To Be Completed by Funeral Director | 19e. Informant's Name/Relationship (Type, Print)
SHELBY JEAN FITZHUGH, NIECE | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
USSAH #703, 3700 N. CAPITOL ST., NW, WASH., DC 20317 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | Date
Jan. 27, 97 | | 20c. Location - City or Town, State
Brentwood, Maryland | | | |
| To Be Completed by Funeral Director | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME
3401 BLADENSBURG RD., BRENTWOOD, MD 20722 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Congestive Heart Failure
Due to (or as a consequence of):
Atrial Fibrillation
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of):
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
4 Days | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Disease
Anemia | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| To Be Completed by Physician/Medical Examiner | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D03835 | | 29d. Date signed (Month, Day, Year)
January 27, 1997 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David Cromwell, M.D. 831 University Boulevard East, Silver Spring, Maryland 20903 | | | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
JAN 27 1997 | | 32. Registrar's Signature
 | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04237

Certificate of Death

Reg. No.

4 0/4

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA GENEVIEVE FORD HARRIS

2. Date of Death

January 21, 1997

3. Time of Death

9:15 am

4a. Facility Name (If not institution, give street and number)

6312 JOYCE DRIVE

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

P.G.

Funeral
Director

5. Social Security Number

579-72-0163

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-9-05

9. Birthplace (State or Foreign Country)

WASH, DC

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

308 9th STREET, S.E.

10f. Zip Code

20003

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

RICHARD FORD

18. Mother's Name (First, Middle, Maiden Summa)

ANNA HEMSLEY

19a. Informant's Name/Relationship (Type, Print)

MARY H. FREEMAN (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6312 Joyce Dr. Camp Springs, MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MARYLAND NATIONAL

Data

1/25/97

20c. Location - City or Town, State

LAUREL, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

POPE FUNERAL HOME 5538 MARLBORO PIKE
FORESTVILLE, MARYLAND 2074723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Arrhythmia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Congestive heart failure
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):

d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43241

29d. Date signed (Month, Day, Year)

1/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5100 Auth Way

MD 20746

State
Registrar

31. Date filed (Month, Day, Year)

JAN 27 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04238

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|--|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Marie A. Harper | | | | 2. Date of Death
Month Day Year
January 22, 1997 | | | | 3. Time of Death
8:45 am | |
| | 4e. Facility Name (If not institution, give street and number)
3202 Shepherd Street | | | | 4b. City, Town, or Location of Death
Mt. Rainier | | | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
251-34-4061 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 18, 1926 | | 9. Birthplace (State or Foreign Country)
Georgia | |
| | Usual Residence of Decedent | | | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Mt. Rainier | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 10e. Street and Number
3202 Shepherd Street | | | | 10f. Zip Code
20721 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | | 16b. Kind of Business/Industry
Own Home | | | | 17. Father's Name (First, Middle, Last)
Jesse M. Meadows | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Alice O. Deau | | | | 19e. Informant's Name/Relationship (Type, Print)
George C. Harper - Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3202 Shepherd Street, Mt. Rainier, Maryland 20721 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | | | 20c. Location - City or Town, State
Alexandria, Virginia | |
| | 21. Signature of Funeral Service Licensee
D. Constance Gresh | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>Cardiopulmonary Arrest</u>
Due to (or as a consequence of):
b. <u>Congestive Heart Failure</u>
Due to (or as a consequence of):
c. <u>Hypertension</u>
Due to (or as a consequence of):
d.
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospitel: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| 29b. Signature and title of certifier
Gary W. Jones M.D. | | | | 29c. License number
D30111 | | | | 29d. Date signed (Month, Day, Year)
January 25, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gary W. Jones, M.D. 11305 Pitsea Drive, Beltsville, Maryland 20705-1757 | | | | 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | 32. Registrar's Signature
[Signature] | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

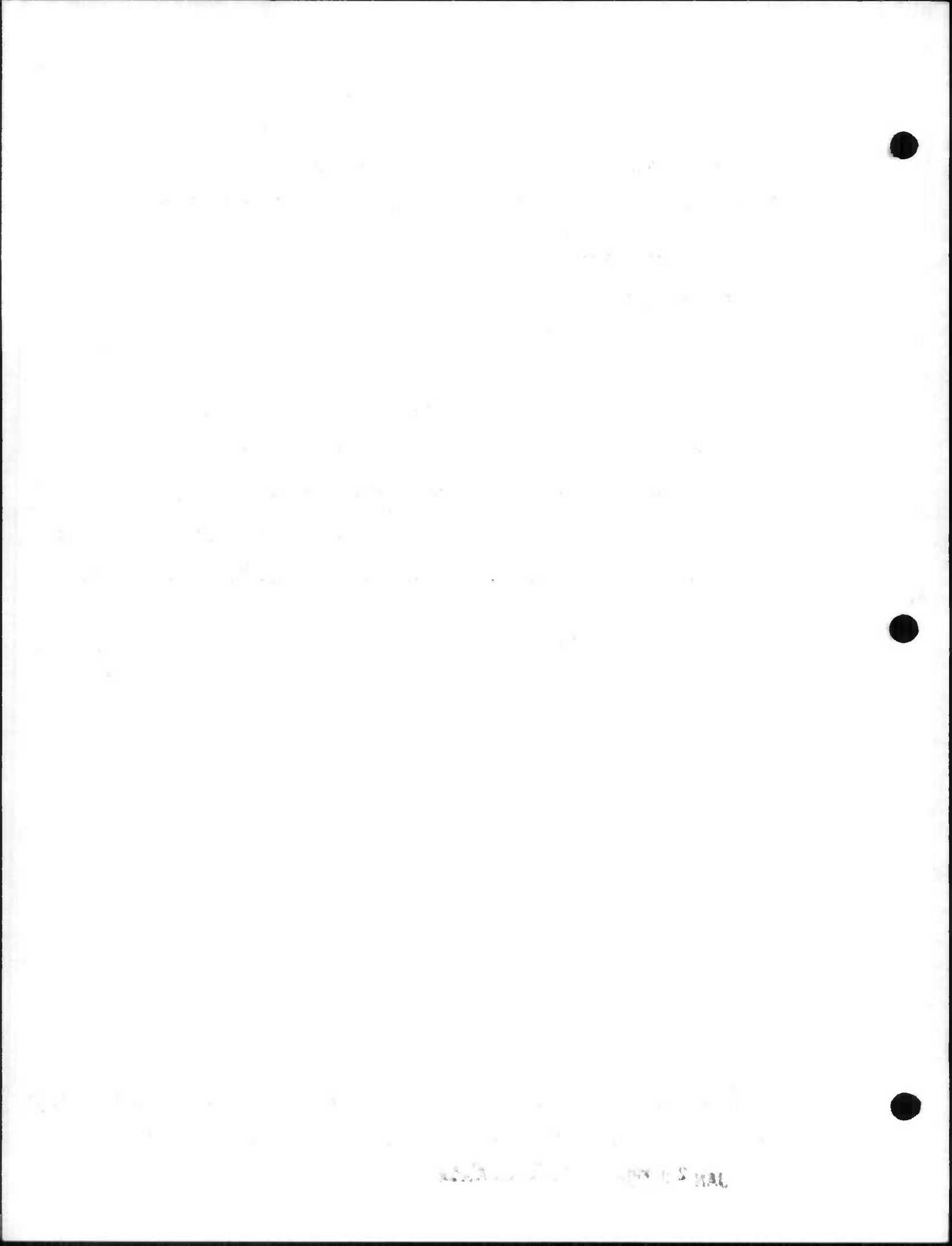
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04239

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNEST RUSSELL HOLMES

2. Date of Death

Month Day Year
JAN 24 1997

3. Time of Death

9:21 AM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577-05-9932

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MARCH 8, 1915

9. Birthplace (State or Foreign Country)

WASHINGTON D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

718 NORTH HAMPTON DRIVE

10f. Zip Code

20903

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RETIRED CAB DRIVER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

JOHNNY HOLMES

18. Mother's Name (First, Middle, Maiden Surname)

EDITH SORRIS

19a. Informant's Name/Relationship (Type, Print)

MABLE HOLMES / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

718 NORTH HAMPTON DR. SILVER SPRING, MD. 20903

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATORY INC.

Date
1/25/
97

20c. Location - City or Town, State

BELTSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME

716 KENNEDY ST NW WASHINGTON, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

FIVE DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

AORTIC VALVE STENOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41662

29d. Date signed (Month, Day, Year)

JANUARY, 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SAEED KRONFLI, MD

HOLY CROSS HOSPITAL

31. Date filed (Month, Day, Year)

JAN 28 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE. IMPORTANT: IF ITEM 27 IS MARKED OTHER THAN "NATURAL", OR ITEMS 23a OR 28a-f SHOW ANY INJURY OR OTHER TRAUMATIC EVENT, THE MEDICAL EXAMINER MUST BE NOTIFIED AT ONCE.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04240

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|---|--|--|--------------------------------|-----------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Isaac Hall, Jr. | | | | 2. Date of Death
Month Day Year
January 23, 1997 | | | | 3. Time of Death
11:52A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital | | | | 4b. City, Town, or Location of Death
Clinton | | | | 4c. County of Death
Prince Georges | |
| Funeral
Director | 5. Social Security Number
439-14-5184 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
77 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth (Month, Day, Year)
February 19, 1919 | | 9. Birthplace (State or Foreign Country)
Louisiana | | 10a. State | | 10b. County | | 10c. City, Town or Location | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| | 10e. Street and Number
4032 D Street, S.E. | | | | 10f. Zip Code
20019 | | | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Navar Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
12 Collage (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Steel Fabricator | | | | 16b. Kind of Business/Industry
Construction | |
| | 17. Father's Name (First, Middle, Last)
Isaac Hall, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Rosa Parker | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Miriam Hall/Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4032 D Street, S.E. Washington, D.C. 20019 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | | | 20c. Location - City or Town, State
1-28-97 Brentwood, Maryland | |
| | 21. Signature of Funeral Service Licensee
Lisa S. Johnson | | | | 22. Name and Address of Facility
Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, Maryland 20722 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death
MINUTES
HOURS | | | | | |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ALZHEIMER'S DEMENTIA | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how injury occurred | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
George Bone, M.D. | | | | 29c. License number
D31069 | | |
| 29d. Date signed (Month, Day, Year)
1/24/97 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
George Bone, M.D. 9602 F Martin Luther King, Jr. Highway Lanham, Maryland 20706 | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | 32. Registrar's Signature
[Signature] | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04241

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BRYAN HALL | | 2. Date of Death
Month Day Year
JANUARY 7, 1997 | | 3. Time of Death
12:05 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL | | 4b. City, Town, or Location of Death
CHEVERLY | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
458-21-0974 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
36 | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Mar 17, 1960 | | 9. Birthplace (State or Foreign Country)
Monroe, LA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10c. City, Town or Location | | |
| | 10a. State
Maryland | 10b. County
Prince Georges | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
10609 Joyceton Avenue | | 10f. Zip Code
20772 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: Unk | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Computer Programmer | | 16b. Kind of Business/Industry
Electronics | | |
| | 17. Father's Name (First, Middle, Last)
Aldolph Chisolm | | 18. Mother's Name (First, Middle, Maiden Surname)
Avis Hall | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Spencer Funeral Home | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4000 Miller Ave., FT. Worth, Tex. 76119 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Memorial Park | | 20c. Location - City or Town, State
1/25/97 Arlington, Texas |
| | 21. Signature of Funeral Service Licensee
Alexander S. Pope, Jr. | | 22. Name and Address of Facility
Alexander S. Pope Funeral Home
2617 Pennsylvania Ave, SE, Washington, DC 20020 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
Dennis J. Chute | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JANUARY 8, 1997 |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dennis Chute 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
JAN 28 1997 | | 32. Registrar's Signature
John A. Hunter-Rodell | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

20b

State of Maryland / Department of Health and Mental Hygiene

97 04242

Items: 4a,10e,19b per F.H. G-744 2/19/97 re **Certificate of Death**

Reg. No.

| | | | | | | | | | | |
|---|---|---|--|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Francis DeSales Johnson | | | | 2. Date of Death
Month Day Year
January 23, 1997 | | | | 3. Time of Death
7:45 am | |
| | 4a. Facility Name (If not institution, give street and number)
6000 42nd Street #512 | | | | 4b. City, Town, or Location of Death
Hyattsville | | | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
214-14-1319 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
March 15, 1920 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Prince George's | | 10c. City, Town or Location
Hyattsville | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
6000 42nd Street #512 | | | | 10f. Zip Code
20781 | | | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Construction Engineer | | | | 16b. Kind of Business/Industry
Private Industry | | |
| 17. Father's Name (First, Middle, Last)
Francis D. Johnson | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Lucy M. Mattingly | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Bertha Johnson - Spouse | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6000 42nd Street #512, Hyattsville, MD 20781 | | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery | | 20c. Location - City or Town, State
Brentwood, Maryland | | 20d. Date
1/25/97 | | | | |
| 21. Signature of Funeral Service Licensee
W. B. Gasch | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION SUDEN
Due to (or as a consequence of):
b. HYPERTENSION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE LUNG - DISEASE | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
K. Joseph Mathew M.D. | | | | 29c. License number
014799 | | 29d. Date signed (Month, Day, Year)
January 23, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K. Joseph Mathew, M.D. 6510 Kenilworth Avenue, Riverdale, Maryland 20737-1347 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | 32. Registrar's Signature
John Andrew Radell | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04243

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN KILLETTE

2. Date of Death

FEBRUARY 1, 1997

3. Time of Death

23:10 PM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Maryland

Funeral
Director

5. Social Security Number

215-16-3591

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 11, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1755 Cliftview Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

6

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Vegetable Line Helper

16b. Kind of Business/Industry

Vegetable Packing Plant

17. Father's Name (First, Middle, Last)

John Wesley Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Noble

19a. Informant's Name/Relationship (Type, Print)

Julia Loftin (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1755 Cliftview Ave. Baltimore, MD, 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Washington Cemetery 2/7/97 Hurlock, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

HENRY FUNERAL HOME
510 Washington St. Cambridge, MD, 2161323a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

30 min

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Multiple Pulmonary Emboli

Due to (or as a consequence of):

6 hrs 30 min

c. Brain Tumor

Due to (or as a consequence of):

9 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Prudence Jackson, MD

29c. License number

D-37659

29d. Date signed (Month, Day, Year)

February 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Prudence Jackson, MD, 900 cator Avenue, Baltimore, Maryland 21229

31. Date filed (Month, Day, Year)

FEB 4 1997

32. Registrar's Signature

John Andrew Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 04244

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ELIZABETH M. KELLY | | | | 2. DATE OF DEATH
MONTH JANUARY DAY 25 YEAR 1997 | | 3. TIME OF DEATH
1:40 A.M. | |
| 4. SOCIAL SECURITY NUMBER
220-38-0648 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
93 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
JUNE 05 1903 | | 8. BIRTHPLACE (State or Foreign Country)
MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number)
EGL E NURSING HOME | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
LONA CONING | | 9c. COUNTY OF DEATH
ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MARYLAND | | 10b. COUNTY
ALLEGANY | | 10c. CITY, TOWN OR LOCATION
LONA CONING | | 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
14 WATERCLIFF ST | | | | 10f. ZIP CODE
21539 | | 10g. CITIZEN OF WHAT COUNTRY?
UNITED STATES | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) UNKNOWN | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY
HOME | | | |
| 17. FATHER'S NAME (First, Middle, Last)
FELIX FOOTE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
SARAH WRIGHT | | | |
| 19a. INFORMANT'S NAME (Type/Print)
George Kelly | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20 Florida Way, Lonaconing, Md. 21539 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
OAK HILL CEMETERY | | 20c. DATE
1-28-97 | | 20d. LOCATION — City or Town, State
LONA CONING MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>F. Wayne Boal</i> | | | | 22. NAME AND ADDRESS OF FACILITY
BOAL FUNERAL HOME
111 CHURCH ST WESTERNPORT, MD 21562 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i> | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Dementia, Chronic atrial fibrillation, Hypertension</i> | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>Thomas J. Decker MD</i> | | | | 29c. LICENSE NUMBER
D21488 | | 29d. DATE SIGNED (Month, Day, Year)
1-27-97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Thomas J. Decker MD, 20 Douglas Avenue, Lonaconing, MD 21539 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 29 1997 | | 32. REGISTRAR'S SIGNATURE
<i>Julia Davidson Randall</i> | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04245

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AUGUSTA

KRULDER

2. Date of Death

Month Day Year
FEBRUARY 2, 1997

3. Time of Death

11:30 PM

4a. Facility Name (If not institution, give street and number)

38401 PLEASANT VIEW DRIVE

4b. City, Town, or Location of Death

CHARLOTTE HALL

4c. County of Death

ST. MARY'S

Funeral
Director

5. Social Security Number

067-16-3550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MARCH 28, 1921

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ST. MARY'S

10c. City, Town or Location

CHARLOTTE HALL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

38401 PLEASANT VIEW DRIVE

10f. Zip Code

20622

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

HENRY CHARLES MEYER

18. Mother's Name (First, Middle, Maiden Surname)

SARAH MCENTI

19a. Informant's Name/Relationship (Type, Print)

GERALDINE SOPER / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

37775 INDIAN CREEK DRIVE, CHARLOTTE HALL, MD 20622

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEMORIAL GARDENS 2/05/1997 WALDORF, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensed

JPK

MARK G. BROHAWN

MD00053

22. Name and Address of Facility

THE HUNTI FUNERAL HOME, INC.

P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D26358

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN H. WEIGEL, MD 120 HOSPITAL DRIVE, #200, PRINCE FREDERICK, MD 20678

31. Date filed (Month, Day, Year)

FEB 04 1997

32. Registrar's Signature

John H. Weigel

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04246

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANN V.

2. Date of Death

Month Day Year

JANUARY 28, 1997

3. Time of Death

6:50pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

ASSN GLEN BARNE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

103 05 1750

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 20, 1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1642 Eton Way

10f. Zip Code

21114

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (14 or 5+)

Collage (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Industrial

Manufacturing Company

17. Father's Name (First, Middle, Last)

Stanley Zajac

18. Mother's Name (First, Middle, Maiden Surname)

Rose Kaczorek

19a. Informant's Name/Relationship (Type, Print)

Joan B. Kneibert Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1642 Eton Way Crofton Maryland 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Charles Cemetery

2/3/97

Date

20c. Location - City or Town, State

Farmingdale New York

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac Arrest

Due to (or as a consequence of):

b. Acute MI

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/o heart cancer

osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 31 1997

John Andrew Rodell

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04247

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PRESTON LOUIS LEIGHTON | | | | 2. Date of Death
Month 2 Day 2 Year 1997 | | 3. Time of Death
5:30pm | |
| | 4a. Facility Name (If not institution, give street and number)
35 Snug Harbor Way | | | | 4b. City, Town, or Location of Death
Earleville | | 4c. County of Death
Cecil | |
| Funeral
Director | 5. Social Security Number
164-09-1361 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
90 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
3-30-1906 | 9. Birthplace (State or Foreign Country)
Phila, PA. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
Cecil | | 10c. City, Town or Location
Earleville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
35 Snug Harbor Way | | | | 10f. Zip Code
21919 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Salesman | | | | 16b. Kind of Business/Industry
Chemical Manufacture | |
| | 17. Father's Name (First, Middle, Last)
Frank Leighton | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Henrietta Wylie | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Hazel Leighton (wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
35 Snug Harbor Way Earleville, MD. 21919 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stephen's Cemetery | | 20c. Location - City or Town, State
Earleville, MD. | | 20d. Location - City or Town, State | |
| | 21. Signature of Funeral Service Licensee
 M00510 | | | | 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaeck
Box 235 Galena, MD. 21635 | | | |
| | 23s. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c. COPD
Due to (or as a consequence of):
d. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Parkinson's Disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
130291 | | 29d. Date signed (Month, Day, Year)
2/3/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Denitzio, MD Box 415 Cecilton, MD 21913 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 04 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04248

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | |
|---|--|---------------------------|---|---|---|--|--------------------------------|--|--|-----------------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HELENE LUDWIG | | | | 2. Date of Death
JAN. 27, 1997 | | | | 3. Time of Death
6:45 PM | | | | | |
| | 4e. Facility Name (If not Institution, give street and number)
NATIONAL LUTHERAN HOME | | | | 4b. City, Town, or Location of Death
ROCKVILLE | | | | 4c. County of Death
MONTGOMERY CO. | | | | | |
| Funeral
Director | 5. Social Security Number
137-32-6605 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth (Month, Day, Year)
APR. 13, 1922 | | 9. Birthplace (State or Foreign Country)
GERMANY | |
| | Usual Residence of Decedent | | | | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
MONTGOMERY | | 10c. City, Town or Location
ROCKVILLE | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| 10e. Street and Number
16-ORCHARD WAY, S. | | | | 10f. Zip Code
20854 | | | | 10g. Citizen of What Country?
U.S.A. | | | | | | |
| 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4or 5+)
NOT AVAILABLE | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SEAMSTRESS | | | | 16b. Kind of Business/Industry
BILL BLASS | | | | | | |
| 17. Father's Name (First, Middle, Last)
KARL LUDWIG | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
EMILIA PFIZERMAIER | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
CAROL VOROSMARTI | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16- ORCHARD WAY, S., ROCKVILLE, MD. 20854 | | | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY-1/28 | | | | 20c. Location - City or Town, State
ALEXANDRIA, VA. | | | | | | |
| 21. Signature of Funeral Service Licensee
William Hysong | | | | | | 22. Name and Address of Facility
HYSONG CO., INC.
1300-N ST., NW, WASH., DC | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Arteriosclerosis
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Approximate Interval Between Onset and Death
minutes
years
years | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypocholesterolemia
Peripheral Arterial Insufficiency
Aortic Stenosis | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Daniel A. Saller | | | | | | 29c. License number
D33138 | | 29d. Date signed (Month, Day, Year)
1-28-97 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Daniel A Saller, 9701 Veirs Dr. Rockville, MD | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 31 1997 | | | | 32. Registrar's Signature
John R. R. R. | | | | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04249

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Wade Henry Lansberry

2. Date of Death

Month
02Day
02Year
97

3. Time of Death

8:21 P.M.

4a. Facility Name (If not institution, give street and number)

Cuppett Weeks Nursing Home

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

236-20-1482

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 4, 1906

9. Birthplace (State or Foreign Country)

WV.

Usual Residence of Decedent

10a. State

WV.

10b. County

Tucker

10c. City, Town or Location

St. George

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 2 Box 282

10f. Zip Code

26290

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

Collega (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Logger

16b. Kind of Business/Industry

Forestry

17. Father's Name (First, Middle, Last)

Charles Wesley Lansberry

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Ashbaugh

19e. Informant's Name/Relationship (Type, Print)

John Lansberry/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 2 box 283 St. George, WV. 26290

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rose Hill Cemetery

Date

2/5/97

20c. Location - City or Town, State

Thomas, WV.

21. Signature of Funeral Service Licensee

J. Scott Hinkle

22. Name and Address of Facility

Hinkle Funeral Home

P.O. Box 186 Davis, WV. 26260

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

2 days

b. Hypertensive Cardiomyopathy

Due to (or as a consequence of):

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Scott Hinkle, M.D.

29c. License number

D33464

29d. Date signed (Month, Day, Year)

February 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert M. Coughlin, M.D. P.O. Box 8, Eggleston, WV 26716

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

John A. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04250

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

RENEE LEWIS

2. Date of Death
Month Day Year

JANUARY 29, 1997

3. Time of Death

4:00 A.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

578-92-8370

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

33

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

08/03/63

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

Maryland Prince George's

10e. Street and Number

6501 W. Forrest Drive

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Computer Technician

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Lester Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Mahoney

19a. Informant's Name/Relationship (Type, Print)

Phyllis Lewis/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11350 Evans Trail #103 Beltsville, Md 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial Park

Date

2/4/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Percantie

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover Md 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Mycobacterium Systemic Infection 2 MOS

Due to (or as a consequence of):

b. HIV Infection 5 YRS

Due to (or as a consequence of):

c. Blood transfusions 7 YRS

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumocystis Pneumonia
Anemia Secondary to HIV

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Linda D Green MD

29c. License number

D 21428

29d. Date signed (Month, Day, Year)

JAN 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA D GREEN MD

PRINCE GEORGES HOSPITAL CENTER

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

John R. Ricketts

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04251

Reg. No.

| | | | | | |
|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PASQUALE LIGNELLI | | 2. Date of Death
Month Jan Day 28th Year 1997 | | 3. Time of Death
6:10 AM |
| | 4a. Facility Name (If not institution, give street and number)
6723 LAMONT DRIVE | | 4b. City, Town, or Location of Death
LANHAM | | 4c. County of Death
PRINCE GEORGES |
| Funeral
Director | 5. Social Security Number
578 30 9475 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Sept. 19, 1913 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Lanham | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 10e. Street and Number
6723 Lamont Drive | | | 10f. Zip Code
20801 | | 10g. Citizen of What Country?
United States |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Barber | | 16b. Kind of Business/Industry
Barber Shop |
| 17. Father's Name (First, Middle, Last)
Alfonso Lignelli | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marguerite Martini | | |
| 19a. Informant's Name/Relationship (Type, Print)
Alphonso Lignelli Son | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3583 Scheel Drive Ellicott City Maryland 21042 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 1/31/97 | | 20c. Location - City or Town, State
Brentwood Maryland | |
| 21. Signature of Funeral Service Licensee
Robert E. Evans, Pres | | | 22. Name and Address of Facility
Robert E. Evans Funeral Home, P.A.
16000 Annapolis Rd. Bowie Maryland 20715 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. RESPIRATORY ARREST
Due to (or as a consequence of):</p> <p>b. METASTATIC CARCINOMA LUNG
Due to (or as a consequence of):</p> <p>c. EMPHYSEMA
Due to (or as a consequence of):</p> <p>d. CHRONIC BRONCHITIS
Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p>6 months</p> <p>10 years</p> <p>12 years</p> </div> </div> | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ABDOMINAL AORTIC ANEURYSM
ATHEROSCLEROTIC VASCULAR DISEASE | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
[Signature] | | 29c. License number
221883 | | 29d. Date signed (Month, Day, Year)
1/28/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HEMA PYADLA, O.D.; 9470 ANNAPOLIS RD SUITE #308 LANHAM MD - 20706 | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 31 1997 | | 32. Registrar's Signature
[Signature] | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04252

10 1/9

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS

LYLES

2. Date of Death

Month JANUARY Day 24 Year 1997

3. Time of Death

12:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

220-16-5004

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 24, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Suitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3940 Bexley Place #908

10f. Zip Code

20746

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private Home

17. Father's Name (First, Middle, Last)

CLARENCE LYLES

18. Mother's Name (First, Middle, Maiden Surname)

ELENORA DENT

19a. Informant's Name/Relationship (Type, Print)

MARYL L. YOUNG (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2524 Dear Field Dr., Ruther Glen, VA 22254

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial Park

Date

2/1/97

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Alex S. Pope Jr.

M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 Marlboro Pike, Forestville, MD, 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Brain Death

a. Due to (or as a consequence of):

Cerebral vascular accident

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pelvic fracture

Multiple lower extremity fractures

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)
1/21/9728b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Pedestrian struck

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

L. Bahadori

29c. License number

D47928

29d. Date signed (Month, Day, Year)

1/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Bahadori

Prince Georges Hospital Center

31. Date filed (Month, Day, Year)

JAN 27 1997

32. Registrar's Signature

John A. Kimball

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04253

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES LOGAN | | | | 2. Date of Death
Month Day Year
January 25 1997 | | 3. Time of Death
11:45 a.m. | | |
| | 4a. Facility Name (If not institution, give street and number)
Mediplex of Montgomery Village Nursing Home | | | | 4b. City, Town, or Location of Death
Gaithersburg | | 4c. County of Death
Montgomery | | |
| Funeral
Director | 5. Social Security Number
066-22-8611 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
02 04 1930 | | |
| | 9. Birthplace (State or Foreign Country)
Ohio | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Camp Spring | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
6107 Summerhill Road | | 10f. Zip Code
20748 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 01/7/48 to 1/10/51 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Photographer | | 16b. Kind of Business/Industry
Government | | 17. Father's Name (First, Middle, Last)
Julian Logan | | 18. Mother's Name (First, Middle, Maiden Surname)
Mindora Goode | |
| 19a. Informant's Name/Relationship (Type, Print)
Betty Logan/Wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6107 Summerhill Rd, Camp Spring, Maryland 20748 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Ceme. | | 20c. Location - City or Town, State
Cheltenham, Maryland | |
| 21. Signature of Funeral Service Licensee
Nancy A. Perentis | | 22. Name and Address of Facility
J. B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. myocardial infarction
Due to (or as a consequence of):
b. anoxic encephalopathy
Due to (or as a consequence of):
c. unwitnessed cardiac arrest
Due to (or as a consequence of):
d. coronary artery disease | | Approximate Interval Between Onset and Death
20 min
1 mo
1 mo
5 yrs | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Dee Beale MD | | 29c. License number
D33443 | | 29d. Date signed (Month, Day, Year)
January 28, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Ann R. Pollack, M.D. 809 Viers Mill Rd Rockville, Md 20851 | | 31. Date filed (Month, Day, Year)
JAN 29 1997 | | 32. Registrar's Signature
Richard Radell | | | | | |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04254

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedant's Name (First, Middle, Last)
JOAN CECILA LEGGETT | | | | 2. Date of Death
Month: January, Day: 28, Year: 1997 | | 3. Time of Death
4:45 am | |
| | 4a. Facility Name (If not institution, give street and number)
4601 68th Place | | | | 4b. City, Town, or Location of Death
Landover Hills | | 4c. County of Death
Prince George's | |
| Funeral
Director | 5. Social Security Number
353-24-8432 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
65 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 11, 1931 | |
| | 9. Birthplace (State or Foreign Country)
Illinois | | 10a. State
MD | | 10b. County
Prince George's | | 10c. City, Town or Location
Landover Hills | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
4601 68th Place | | 10f. Zip Code
20784 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedant Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedant of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedant's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (1-4 or 5+) | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Customer Service Representative | | 16b. Kind of Business/Industry
Furniture Retail | | | |
| | 17. Father's Name (First, Middle, Last)
John Andrew Pavolko | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Catherine Diggle | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Patricia C. Leggett - Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4601 68th Place, Landover Hills, Maryland 20784 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery | | 20c. Location - City or Town, State
Clinton, Maryland | | 20d. Date
01/31/97 | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>Disseminated Breast Cancer</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | Approximate Interval Between Onset and Death
<i>7 years</i> | | | | | | | |
| | Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Takuo Sonoda, M.D.</i> | | | | 29c. License number
036-045379 | | 29d. Date signed (Month, Day, Year)
January 28, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Takuo Sonoda, M.D. 1050 West Perimeter Road, Andrew Air Force Base, MD 20331-6600 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04255

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Martha Etta Mackery | | | | 2. Date of Death
Month Feb Day 2 Year 1997 | | 3. Time of Death
11:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis ElderCare - The Pines | | | | 4b. City, Town, or Location of Death
Easton | | 4c. County of Death
Talbot | |
| Funeral
Director | 5. Social Security Number
216-12-1317 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 31, 1919 Maryland | 9. Birthplace (State or Foreign Country) |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Talbot | | 10c. City, Town or Location
Easton | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
Route 50 + Dutchman's Lane | | | | 10f. Zip Code
21601 | | 10g. Citizen of What Country?
U.S. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic | | 16b. Kind of Business/Industry
Private Family | | | |
| | 17. Father's Name (First, Middle, Last)
William Edward Greene | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Elsie Thomas | | | |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
Mary Camper | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4657 Old Trappe Road Trappe, MD 21673 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Paradise Cemetery | | Date
2/6/97 | | 20c. Location, City or Town, State
Trappe, Maryland | |
| | 21. Signature of Funeral Service Licensee
Janelle C. Henry | | | | 22. Name and Address of Facility
HENRY Funeral Home
510 Washington St. Cambridge, MD 21613 | | | |
| | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Pneumonia
Due to (or as a consequence of):
P.V.S. (Persistent Vegetative State)
Due to (or as a consequence of):
CVA (B)
Due to (or as a consequence of):
HTN | | | | | | | |
| | Approximate Interval Between Onset and Death
3 days
4 months
1 year
75 years | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
045125 | | 29d. Date signed (Month, Day, Year)
2/13/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHELLE ONG, MD 606 DUTCHMAN'S LANE EASTON, MD 21601 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 4 1997 | | 32. Registrar's Signature
Johanna Swickard-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04256

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES Otto MURRAY

2. Date of Death

January 30 1997

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

215-10-1304

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

January 3, 1916

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State
Maryland10b. County
Allegany10c. City, Town or Location
Spring Gap

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 51 Wheeler Road, P.O. Box 105

10f. Zip Code

21560

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

John Adam

Murray

18. Mother's Name (First, Middle, Maiden Surname)

Lulu

Reynolds

19a. Informant's Name/Relationship (Type, Print)

Frances Murray/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 51, Wheeler Rd., Spring Gap, Maryland 21560

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cook's Cemetery

Date

February 1, 1997

20c. Location - City or Town, State

Wellersburg, PA

21. Signature of Funeral Service Licensee

Jennifer Merritt

22. Name and Address of Facility

Merritt-Adams Funeral Home
404 Decatur Street, Cumberland, Maryland 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *acute respiratory failure*

Due to (or as a consequence of):

Approximate interval between Onset and Death

4 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *severe COPD*

Due to (or as a consequence of):

5 years

c. _____

Due to (or as a consequence of):

d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dilated cardiomyopathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert Orino

29c. License number

D34846

29d. Date signed (Month, Day, Year)

January 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Orino 902 Seton Drive, Cumberland, Maryland 21502

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

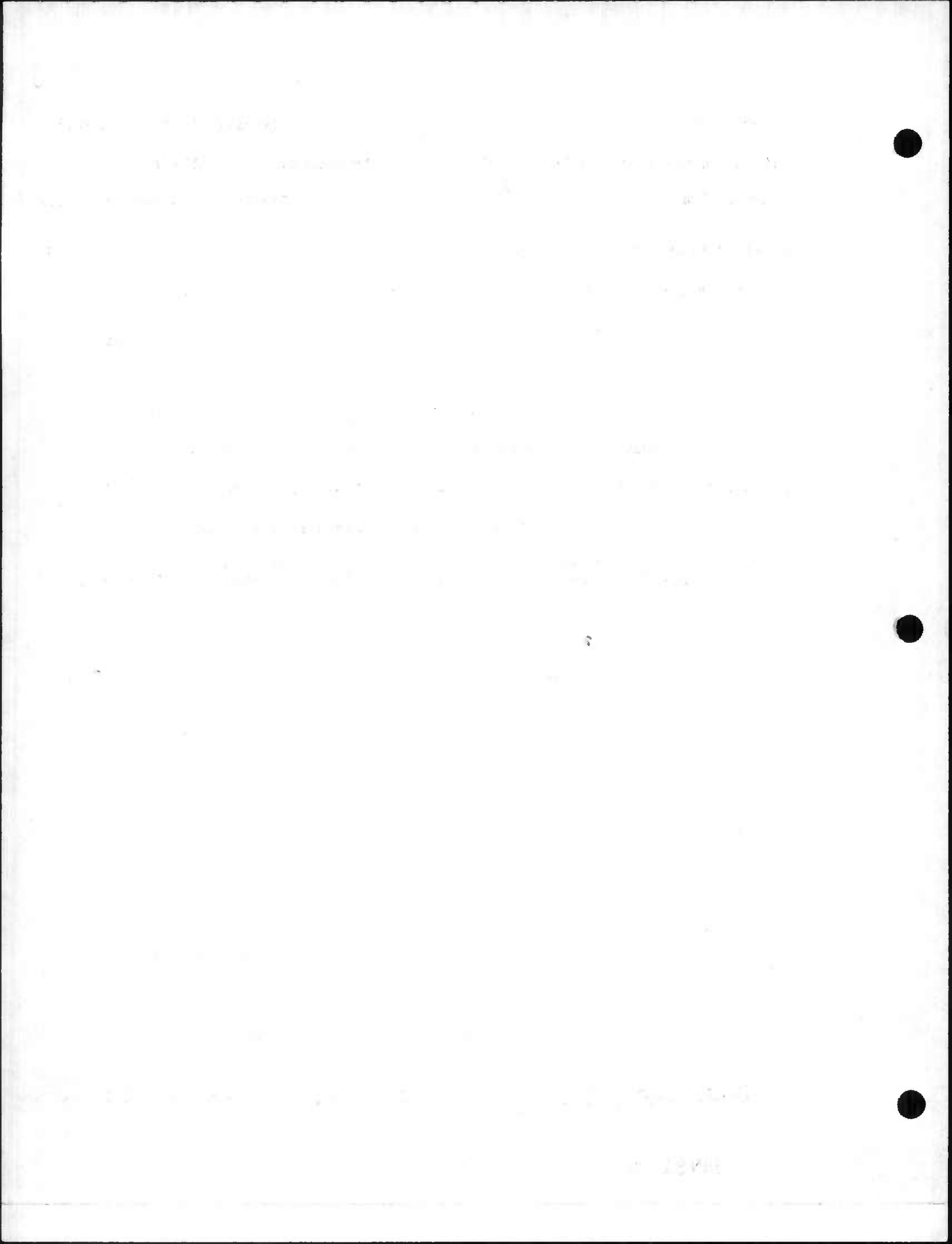
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 04257

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Cora Mae metz | | | | 2. DATE OF DEATH
MONTH DAY YEAR
02 01 97 | | 3. TIME OF DEATH
8:05 A.M. | |
| 4. SOCIAL SECURITY NUMBER
215-18-8320 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
83 YRS. | 7. DATE OF BIRTH (Month, Day, Year)
July 24 1913 | | 8. BIRTHPLACE (State or Foreign Country)
West Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number)
Egle Nursing Home | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Lonaconing | | 9c. COUNTY OF DEATH
Allegany | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Allegany | | 10c. CITY, TOWN OR LOCATION
Barton | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
P.O. Box 154 Piedmont St. | | | | 10f. ZIP CODE
21521 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
Unknown | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Nursing Home Emp. | | 15b. KIND OF BUSINESS/INDUSTRY
Nursing Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
James Swick | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary Armentrout | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mr. Charles Metz | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Box 51 Piedmont St. Barton, Maryland 21521 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Laurel Hill Cemetery 02-04-97 | | 20c. LOCATION — City or Town, State
Barton, Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
Wayne Boal | | | | 22. NAME AND ADDRESS OF FACILITY
Boal Funeral Home
111 Church St. Westernport, Md. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. Congestive Heart Failure | | | | Approximate Interval Between Onset and Death
2 yrs. | |
| | | b. Arteriosclerotic Cardiovascular disease | | | | 4 yrs. | |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | c. _____ | | | | | |
| | | d. _____ | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic diverticulitis | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
James Swick | | | | 29c. LICENSE NUMBER
007004 | | 29d. DATE SIGNED (Month, Day, Year)
2/3/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
H.R. MILLES, JR., M.D. 57 JACKSON ST. LONA CONING MD 21539 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 05 1997 | | | | 32. REGISTRAR'S SIGNATURE
John A. ... | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

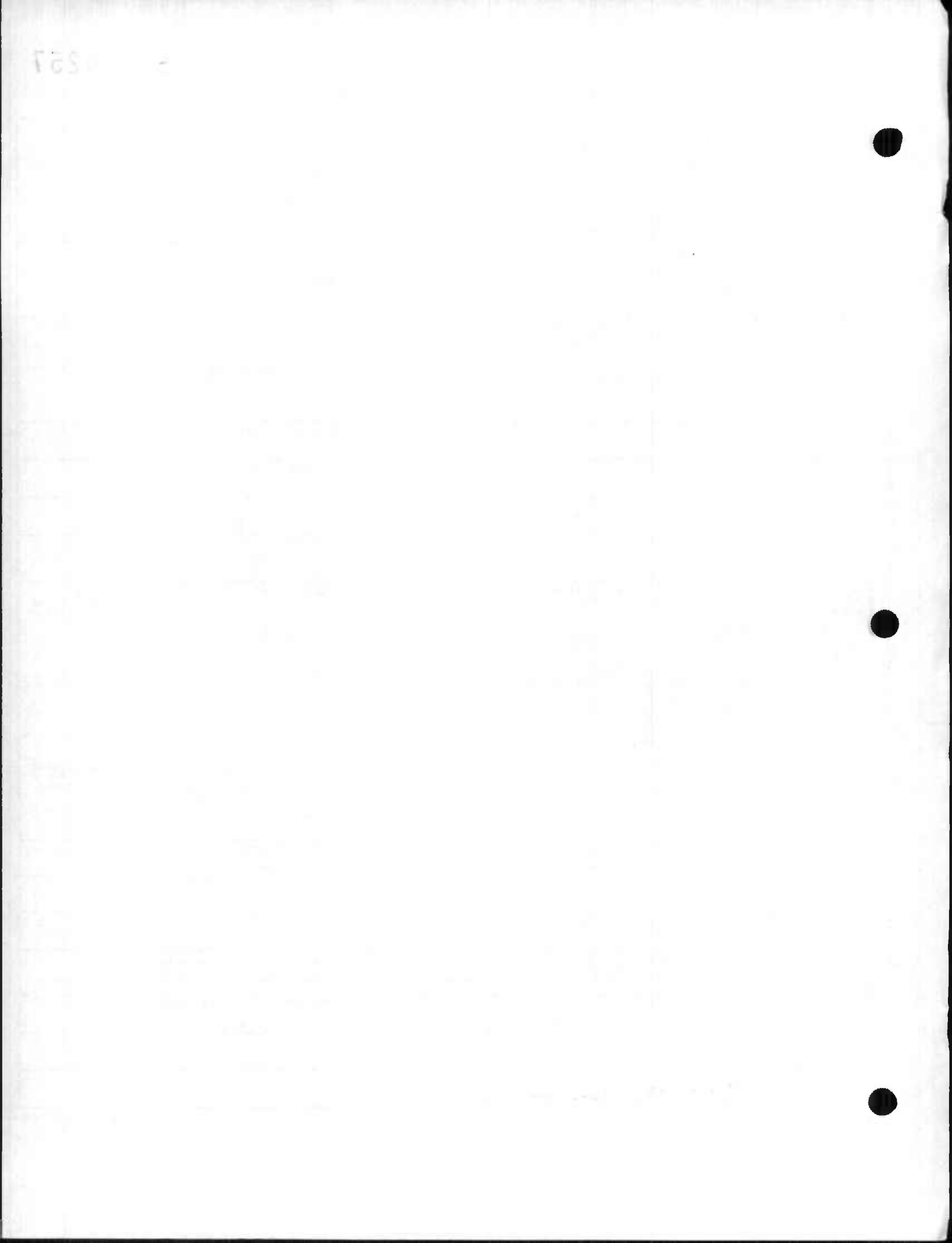
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04258

Certificate of Death

Reg. No.

| | | | | | | | |
|--|---|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Louise Finan Mudd | | | 2. Date of Death
Month Day Year
January 28, 1997 | | 3. Time of Death
5:50pm | |
| | 4a. Facility Name (If not institution, give street and number)
Physicians Memorial Hospital | | | 4b. City, Town, or Location of Death
La Plata | | 4c. County of Death
Charles | |
| Funeral
Director | 5. Social Security Number
212-72-4640 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Jan. 12, 1910 | 9. Birthplace (State or Foreign Country)
MD |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Charles | 10c. City, Town or Location
LaPlata | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
9350 Mudd Farm Lane | | | 10f. Zip Code
20646 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 Collage (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | |
| | 17. Father's Name (First, Middle, Last)
Thomas Bernard Finan | | | 18. Mother's Name (First, Middle, Maiden Surname)
Maude Dolan Finan | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Thomas F. Mudd | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 310 LaPlata, MD 20646 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cem. 1/31/97 | | 20c. Location - City or Town, State
Bryantown, MD | | |
| | 21. Signature of Funeral Service Licensee
April C. Echols | | 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, INC.
P.O. Box 567 LaPlata, MD 20646 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Embolism
Dua to (or as a consequence of):
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Acute Respiratory Infection
Acute Tracheobronchitis
Chronic Obstructive Pulmonary Disease | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
John J. Burke | | 29c. License number
D - 01009 | | 29d. Date signed (Month, Day, Year)
1-28-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Henry Burke, MD 115-A La Grange Avenue, P.O. Box 2539 La Plata, Maryland 20646 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 03 1997 | | 32. Registrar's Signature
John Davidson Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04259

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH ROGERS

MAKLE

2. Date of Death

Month Day Year
January 29, 1997

3. Time of Death

1:02 p.m.

4a. Facility Name (If not institution, give street and number)

15581 Covington Road

4b. City, Town, or Location of Death

Brandywine

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

218-30-2572

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

November 6, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15581 Covington Road

10f. Zip Code

20613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Embassy Dairy Company

17. Father's Name (First, Middle, Last)

William Benjamin Makle

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Savoy Makle

19a. Informant's Name/Relationship (Type, Print)

Rosie L. Makle

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15581 Covington Road, Brandywine, Maryland 20613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Memorial Gardens

Date

February 3, 1997

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility

Adams Funeral Home 20605 Aquasco Road, Aquasco Maryland 20608

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cancer Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 mo

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas L. Feldon MD

29c. License number

001923

29d. Date signed (Month, Day, Year)

Jan 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T-L. Feldon MD Waldorf, MD 20601

31. Date filed (Month, Day, Year)

FEB 04 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

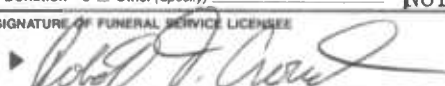
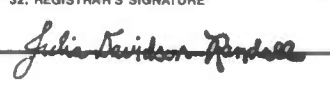
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

97 04260

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Mary Miller Mearns | | | | 2. DATE OF DEATH
MONTH DAY YEAR
January 28, 1997 | | | | 3. TIME OF OATH
1:10 p.m. | | |
| 4. SOCIAL SECURITY NUMBER
218-34-1879 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
94 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
September 25, 1902 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number)
143 Middle Road | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Elkton | | | 9c. COUNTY OF DEATH
Cecil | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Cecil | | 10c. CITY, TOWN OR LOCATION
Elkton | | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | |
| 10e. STREET AND NUMBER
143 Middle Road | | | | 10f. ZIP CODE
21921 | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) 2 | | | 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Nursing Aide | | | 18b. KIND OF BUSINESS/INDUSTRY
Veteran's Medical Facility | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Norman Miller | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ellen Groff | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Clara M. Wyatt | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
143 Middle Road, Elkton, MD 21921 | | | | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
North East Methodist Cem. Jan. 31 1997 | | | 20c. LOCATION — City or Town, State
North East, Maryland | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | | 22. NAME AND ADDRESS OF FACILITY
Crouch Funeral Home
127 South Main Street, North East, MD 21901 | | | | | |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ovarian carcinoma with metastasis
DUE TO (OR AS A CONSEQUENCE OF):
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | | | Approximate Interval Between Onset and Death
1 year | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | 28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | 28d. DESCRIBE HOW INJURY OCCURRED |
| | | | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Monte Makous, MD | | | | | 29c. LICENSE NUMBER
D-44783 | | | 29d. DATE SIGNED (Month, Day, Year)
January 30, 1997 | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MONTE MAKOUS, MD 111 WEST HIGH STREET; ELKTON, MD 21921 | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 30 1997 | | | 32. REGISTRAR'S SIGNATURE
 | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04261

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mae Virginia McGonigal

2. Date of Death

Month

Day

Year

3. Time of Death

02:00

4a. Facility Name (If not institution, give street and number)

Bon Secor Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

217-24-2793

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 25, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1841 McHenry Street

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Ten Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Personal Residence

17. Father's Name (First, Middle, Last)

Joseph Allen McMullen

18. Mother's Name (First, Middle, Maiden Surname)

Mary Louisa Alexander

19a. Informant's Name/Relationship (Type, Print)

Doris Rhodes (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

733 Wheatley Road, North East, Maryland 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hopewell Cemetery

Date

2/4/97

20c. Location - City or Town, State

Port Deposit, Maryland

21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home
Perryville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

b. Endocarditis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage Renal Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Radcliffe M. Thomas M.D.

29c. License number

J42683

29d. Date signed (Month, Day, Year)

February 2 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RADCLIFFE M THOMAS

4000 W NORTHERN PARKWAY

31. Date filed (Month, Day, Year)

FEB 03 1997

32. Registrar's Signature

John Davidson-Rodale

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04262

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Hannah Mullens

2. Date of Death

Feb. 1 1997

3. Time of Death

11:28 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

223-30-0091

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 20 1926

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Conowingo

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

263 Octoraro Rd

10f. Zip Code

21918

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Mose Lowe

18. Mother's Name (First, Middle, Maiden Surname)

Vicebelle Lowe

19a. Informant's Name/Relationship (Type, Print)

Walter J. Mullins, Sr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

263 Octoraro Rd Conowingo MD 21918

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hopewell Cemetery Feb 5 1997

Date

20c. Location - City or Town, State

Port Deposit MD

21. Signature of Funeral Service Licensee

Richard L. Goadie

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.
111 S Queen St. Rising Sun MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

SEPSIS
volvulus & surgical repair

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*COPD and stag**anemia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. P. P. M.

29c. License number

D42800

29d. Date signed (Month, Day, Year)

2/4/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

216000 MD, 318 S. Union Ave, H&B, MD, 21078

31. Date filed (Month, Day, Year)

FEB 04 1997

32. Registrar's Signature

*J. A. Davidson-Rodriguez*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100 00 833

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04263

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEON

MONACHAKANI-BABAYANS

2. Date of Death

JAN.

Day

25, 1997

Year

3. Time of Death

0107 AM

4a. Facility Name (If not institution, give street and number)

20 CINZANO COURT

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

219 02 7475

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 23, 1957

9. Birthplace (State or Foreign Country)

Iran

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2500 Old Largo Road

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Shuttle Service

17. Father's Name (First, Middle, Last)

Gevork M. Babayans

18. Mother's Name (First, Middle, Maiden Surname)

Tatoush Pezeshkian

19a. Informant's Name/Relationship (Type, Print)

Gevork M. Babayans Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2500 Old Largo Rd. Upper Marlboro Maryland 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery 1/30/97

Date

20c. Location - City or Town, State

Brentwood Maryland

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic cardiovascular disease*

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Dixon

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JAN. 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201

State
Registrar

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

A. Dixon

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04264

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA JEANNE MCDERMID

2. Date of Death

January 20 1997

3. Time of Death

7:48 PM

4a. Facility Name (If not institution, give street and number)

9361 Worrell Ave.

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

220-28-5766

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 21 1932

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9361 Worrell Avenue

10f. Zip Code

20706

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Media Aide

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

John David Spaight

18. Mother's Name (First, Middle, Maiden Sumama)

Anna Vivian Mills

19a. Informant's Name/Relationship (Type, Print)

Donald McDermid, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9361 Worrell Ave. Lanham, Md. 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

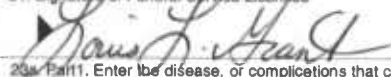
Ft. Lincoln Cemetery

Data

1-24-97 Brentwood, Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Ft. Lincoln F.H. Inc.
3401 Bladensburg Rd. Brentwood, Md. 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. TERMINAL PNEUMONITIS

Due to (or as a consequence of):

DAYS

b. ALZHEIMER'S DISEASE

Due to (or as a consequence of):

YEARS

c. ATHEROSCLEROTIC CEREBROVASCULAR DISEASE

Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No


28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D05401

29d. Date signed (Month, Day, Year)

JANUARY 22 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James W. Harding, M.D. 7525 Greenway Center Dr. Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

JAN 27 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04265

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Eva McNamara

2. Date of Death

January 25, 1997

3. Time of Death

9:35 A. M.

4a. Facility Name (If not institution, give street and number)

307 Ellsworth Place

4b. City, Town, or Location of Death

Oxon Hill

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

292-32-6175

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 7, 1901

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

307 Ellsworth Place

10f. Zip Code

20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Parker

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Jane Pipes

19a. Informant's Name/Relationship (Type, Print)

Kathleen J. Kempton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

307 Ellsworth Pl. Oxon Hill, Md. 20745

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Grove Cemetery

Date

1/27/97

20c. Location - City or Town, State

Gambier, Ohio

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS
YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Louis V. Kaufman

29c. License number

D12906

29d. Date signed (Month, Day, Year)

1/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis V. Kaufman, M.D. 8926 Woodyard Rd. #602 Clinton, Md. 20735

31. Date filed (Month, Day, Year)

JAN 27 1997

32. Registrar's Signature

John Arthur Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04266

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAMON MASON

2. Date of Death

Month Day Year
1-26-97

3. Time of Death

1:40pm

4a. Facility Name (If not institution, give street and number)

HEARTLAND HEALTH CARE

4b. City, Town, or Location of Death

ADELPHI

4c. County of Death

PRINCE GEORGE

Funeral
Director

5. Social Security Number

340-32-7722

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
2-5-32

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

None

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5715 5th st, N.E.

10f. Zip Code

20011

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: 11-56

10-57

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify: 31126

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

John C. Mason

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Harris

19a. Informant's Name/Relationship (Type, Print)

Ramona Mason - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1836 Metzertott Rd. #812, Adelphi, Md 20873

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Quantico National

Date

1-30-97

20c. Location - City or Town, State

Triangle, Va.

21. Signature of Funeral Service Licensee

▶ *Paula de Mateo*

22. Name and Address of Facility

Universal Mortuary Inc.

411 Kennedy St, N.W.

Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Metastatic lung cancer.*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

approx 1 yr

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *[Signature]*

29c. License number

D19609

29d. Date signed (Month, Day, Year)

1-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMAN R. TULI, 3503 PERRY STREET, MT. RAINIER, MD 20712

31. Date filed (Month, Day, Year)

JAN 29 1997

32. Registrar's Signature

▶ *[Signature]*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04267

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|--|---|---|--|---------------------------------------|---|--|---|-----------------------------------|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANK EUGENE MACDONALD | | | | | | 2. Date of Death
Month Jan Day 26 Year 1997 | | 3. Time of Death
2210 | | | |
| | 4a. Facility Name (If not institution, give street and number)
Anne Arundel General Hospital | | | | | | 4b. City, Town, or Location of Death
Annapolis | | 4c. County of Death
Anne Arundel | | | |
| Funeral
Director | 5. Social Security Number
006-24-2930 | | 6. Sex
1 M 2 F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 5, 1930 | | 9. Birthplace (State or Foreign Country)
Massachusetts | | | |
| | Usual Residence of Decedent | | | | | | 10a. State
Maryland | | 10b. County
Prince George's | | 10c. City, Town or Location
Brentwood | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 10e. Street and Number
4415 39th Street | | 10f. Zip Code
20722 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 1951-53 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Hardwood Floor Installer | | | | 16b. Kind of Business/Industry
Self-Employed | | | | | |
| | 17. Father's Name (First, Middle, Last)
Joseph Earl MacDonald | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Betty Davis | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Georgette MacDonald - Wife | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4415 39th Street, Brentwood, Maryland 20722 | | | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | 20c. Date
01/31/97 | | 20d. Location - City or Town, State
Alexandria, Virginia | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | |
| | 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Acute Cardiac Arrhythmia
Due to (or as a consequence of):
b. Arteriosclerotic Heart Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | | | Approximate Interval Between Onset and Death
Minutes | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hyperlipidemia | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown | |
| | 24a. Was an autopsy performed?
1 Yes 2 No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No | |
| 25. Was case referred to medical examiner?
1 Yes 2 No | | | | | | | | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | |
| 27. Manner of Death
1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | | 29b. Signature and title of certifier

Deputy | | 29c. License number
D 06054 | | 29d. Date signed (Month, Day, Year)
1-27-1997 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
William P. Jones, M.D. 695 America Ct. 21035 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97 04268

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MELVINA E. MALONE | | | | 2. DATE OF DEATH
MONTH DAY YEAR
January 28, 1997 | | 3. TIME OF DEATH
8:00 a. M | |
| 4. SOCIAL SECURITY NUMBER
577-52-4050 | | 5. SEX
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
59 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Mar. 29, 1937 | |
| 9a. FACILITY NAME (If not institution, give street and number)
3906 Patterson Avenue | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Baltimore | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 10e. STREET AND NUMBER
3906 Patterson Avenue | | | |
| 10f. ZIP CODE
21207 | | | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: African American | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Secretary | | 16b. KIND OF BUSINESS/INDUSTRY
Government - Bureau of Engraving | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Reginald Wright | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Julia Gordon | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Warren N. Malone - Husband | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3906 Patterson Avenue, Baltimore, MD 21207 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Maryland National Memorial Park | | 20c. DATE
2/1/97 | | 20d. LOCATION — City or Town, State
Laurel, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>John T. Stewart III</i> | | | | 22. NAME AND ADDRESS OF FACILITY
STEWART FUNERAL HOME, Inc.
4001 Benning Road, N.E., Washington, D.C. | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | | a. <i>Myocardial infarction - S.A. tissue - Sarcopenia</i> | | | | | |
| | | b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| | | d. DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>David Van Echo</i> | | | | 29c. LICENSE NUMBER
D25432 | | 29d. DATE SIGNED (Month, Day, Year)
1/28/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
David Van Echo, M.D.
22 South Greene St Baltimore, Maryland 21201 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
JAN 30 1997 | | | | 32. REGISTRAR'S SIGNATURE
<i>John A. Randall</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04269

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
KENNETH O'NEIL NELSON | | | | 2. Date of Death
Month JANUARY Day 25 Year 1997 | | 3. Time of Death
7:11pm | |
| | 4a. Facility Name (If not institution, give street and number)
DOCTORS COMMUNITY HOSPITAL | | | | 4b. City, Town, or Location of Death
LANHAM-SEABROOK | | 4c. County of Death
PRINCE GEORGE'S CO. | |
| Funeral
Director | 5. Social Security Number
579-66-3612 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
45 Yrs. | | 8. Date of Birth (Month, Day, Year)
12/3/51 | |
| | 9. Birthplace (State or Foreign Country)
RUTHERGLEN, VA. | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
PG | | 10c. City, Town or Location
RIVERDALE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
5610 54TH AVENUE #311 | | | | 10f. Zip Code
20737 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 YEARS | | College (1-4 or 5+) NONE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SECURITY | | 16b. Kind of Business/Industry
SECURITY | |
| | 17. Father's Name (First, Middle, Last)
IVON NELSON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LUCY COLEMAN | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
SUSAN NELSON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SAME AS 10A, B, C, D, E, & F | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HARMONY MEMORIAL PARK | | Date
1/30/97 | | 20c. Location - City or Town, State
LANDOVER, MD. | |
| | 21. Signature of Funeral Service Licensee
<i>Juan Smith</i> | | | | 22. Name and Address of Facility
JOHN T. RHINES CO., INC.
3030 12TH ST NE, DC 20017 | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Cerebral edema
Due to (or as a consequence of):
b. Massive Cerebral Vascular Accident 6 days
Due to (or as a consequence of):
c. Internal carotid artery occlusion 1 yr
Due to (or as a consequence of):
d. Uncontrolled Diabetes Mellitus 15 yrs
Approximate Interval Between Onset and Death
18 hr | | | | | | | |
| | Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
hypertensive cardiovascular disease | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Wesley R</i> | | 29c. License number
234860 | | 29d. Date signed (Month, Day, Year)
1/26/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
OLEG SHPAK, 9470 ANNAPOLIS ROAD, SUITE 210, LANHAM MD, 20706 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | 32. Registrar's Signature
<i>John Andrew Ruckel</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04270

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sophia Hartel Podell

2. Date of Death

Month Day Year
January 25, 1997

3. Time of Death

6:00 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

8912 Briarcroft Lane

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

098-38-6182

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan 09, 1916

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8912 Briarcroft Lane

10f. Zip Code

20708

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Xavier Hartel

18. Mother's Name (First, Middle, Maiden Surname)

Maria Weiss

19a. Informant's Name/Relationship (Type, Print)

Peter Podell son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8912 Briarcroft Lane, Laurel, Maryland 20708

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

1/28/97

20c. Location - City or Town, State

Port Chester, New York

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jacob Cherian

29c. License number

D0050973

29d. Date signed (Month, Day, Year)

Jan 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACOB CHERIAN Columbia Med Plan, Two Knoll North, Columbia MD 21045

31. Date filed (Month, Day, Year)

JAN 27 1997

32. Registrar's Signature

John Michael Riedel

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04271

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|--|---|--|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruth Naomi Pardew | | | | 2. Date of Death
Month Jan , Day 26 , Year 1997 | | | | 3. Time of Death
2:30 pm | | |
| | 4a. Facility Name (If not institution, give street and number)
13907 Gardner Avenue | | | | 4b. City, Town, or Location of Death
Ellerslie | | | | 4c. County of Death
Allegany | | |
| Funeral
Director | 5. Social Security Number
212-76-6320 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb 19, 1908 | | 9. Birthplace (State or Foreign Country)
MD | | |
| | Usual Residence of Decedent | | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Funeral Director | 10e. Street and Number
706 Montgomery Avenue | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 18b. Kind of Business/Industry
Own Home | | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Couter | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Virgie (NMN) | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Carole Korn's-daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13907 Gardner Avenue Ellerslie MD 21529 | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chaneyville Cem | | Date
01/29 | | 20c. Location - City or Town, State
Chaneyville, PA | | | | |
| | 21. Signature of Funeral Service Licensee
Nicholas J. Scarpelli | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. HYPERTENSION
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
10 yrs | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CORONARY HEART DISEASE | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA | | 28. Place of Death (Check only one)
Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Dr. Robustiano Barrera | | | | 29c. License number
D 14865 | | 29d. Date signed (Month, Day, Year)
JAN. 28, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Robustiano Barrera Memorial Hospital Medical Building Cumberland | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

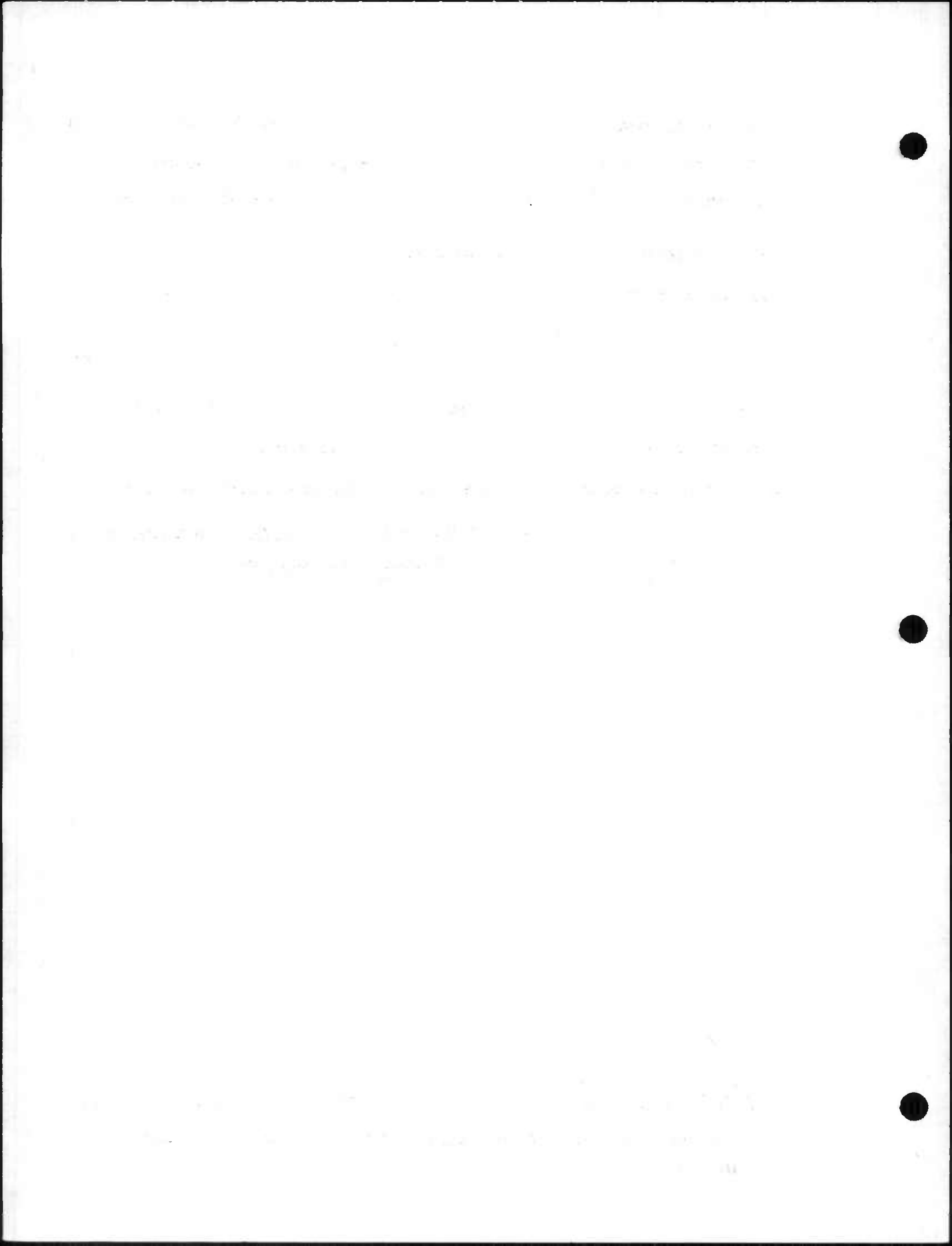
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04272

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLORIA E. POLING

2. Date of Death

JANUARY 31 1997

3. Time of Death

10:30 p.m.

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

336-12-2266

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR 30, 1925

9. Birthplace (State or Foreign Country)

IL

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Wiley Ford

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P.O. Box 41

10f. Zip Code

26767

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Postmaster

16b. Kind of Business/Industry

Post Office

17. Father's Name (First, Middle, Last)

Anton Kuzel

18. Mother's Name (First, Middle, Maiden Surname)

Anna (nmn)

19a. Informant's Name/Relationship (Type, Print)

Jon Poling-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 7th Avenue Cut Bank MT 59427

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

02-04

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. LEUKEMIA

Due to (or as a consequence of):

c. PNEUMONIA

Due to (or as a consequence of):

d. RENAL FAILURE

Approximate Interval Between Onset and Death

3 yrs

4 mos

3 yrs

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

Robert Orlovski

29c. License number

D46104

29d. Date signed (Month, Day, Year)

JANUARY 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT ORLOWSKI

600 N. WOLF ST

BALTIMORE 21201

31. Date filed (Month, Day, Year)

FEB 03 1997

32. Registrar's Signature

John A. Harkness

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04273

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Naomi M

2. Date of Death

January 28 1997

3. Time of Death

10:49 pm

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

217-68-6349

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 2 1951

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Newburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15455 Matthew Manor Rd.

10f. Zip Code

20664

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Store Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Thomas Jefferson Beach

18. Mother's Name (First, Middle, Maiden Surname)

Ola Zenobia Williams Beach

19a. Informant's Name/Relationship (Type, Print)

Thomas Beach

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15455 Matthew Manor Rd. Newburg, MD 20664

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Ghost Cem.

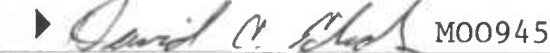
Date

2/1/97

20c. Location - City or Town, State

Issue, MD

21. Signature of Funeral Service Licensee

 M00945

AREHART-ECHOLS FUNERAL HOME, INC.

P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cancer of lung

Due to (or as a consequence of):

b.

Cancer of bladder (urinary)

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

6 mos

5 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure on dialysis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D02915

29d. Date signed (Month, Day, Year)

1-29-97

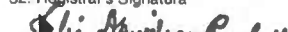
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Daniel Howell M.D. 11315 Pembroke Sq. Ste. 104 Waldorf, MD

31. Date filed (Month, Day, Year)

FEB 03 1997

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


To Be Completed by Funeral Director

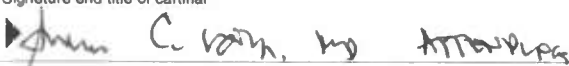

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04274

Reg. No.

| | | | | | | | | | | |
|--|---|--------------------------------|--|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<div style="text-align: center;">Jacqueline Powell</div> | | | | | 2. Date of Death
Month: January Day: 23, Year: 1997 | | 3. Time of Death
2:10 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
<div style="text-align: center;">Doctors Community Hospital</div> | | | | | 4b. City, Town, or Location of Death
<div style="text-align: center;">Lanham</div> | | 4c. County of Death
<div style="text-align: center;">Prince Georges</div> | | |
| Funeral
Director | 5. Social Security Number
578-22-2151 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 22, 1924 | | 9. Birthplace (State or Foreign Country)
Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Prince George's | | 10c. City, Town or Location
Seabrook | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 10e. Street and Number
6907 Presley Road | | | | | 10f. Zip Code
20706 | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary / Bookkeeper | | | 16b. Kind of Business/Industry
Private Industry | | |
| 17. Father's Name (First, Middle, Last)
Amos Wilhide | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Edna Kennedy | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Walter F. Powell - Husband | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6907 Presley Road, Seabrook, Maryland 20706 | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | | Date
01/25/97 | | 20c. Location - City or Town, State
Alexandria, Virginia | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 65%;"> <p>a. ACUTE ON CHRONIC RESPIRATORY FAILURE 1 hr</p> <p>Due to (or as a consequence of):</p> <p>b. CHRONIC OBSTRUCTIVE LUNG DISEASE 15 yrs</p> <p>Due to (or as a consequence of):</p> <p>c. CHRONIC CIGARETTE SMOKING 50 yrs</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
D16197 | | 29d. Date signed (Month, Day, Year)
1-23-97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANDRES C. LOPEZ, MD, 9326 LANHAM - SEABROOK RD., LANHAM, MD 20706 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | 32. Registrar's Signature
 | | | | | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04275

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Edward G. Ridgley</u> | | | | 2. Date of Death
Month <u>JAN</u> Day <u>28</u> Year <u>97</u> | | 3. Time of Death
<u>0623</u> | |
| | 4e. Facility Name (If not institution, give street and number)
<u>Howard County General Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Columbia</u> | | 4c. County of Death
<u>Howard</u> | |
| Funeral
Director | 5. Social Security Number
<u>218-14-6970</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>73</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>March 1, 1923</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>Maryland</u> | | 10a. State
<u>Maryland</u> | | 10b. County
<u>Howard</u> | | 10c. City, Town or Location
<u>Ellicott City</u> | |
| To Be Completed by Funeral Director | 10e. Street and Number
<u>4449 Centennial Lane</u> | | 10f. Zip Code
<u>21042</u> | | 10g. Citizen of What Country?
<u>United States</u> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: <u>WWII</u> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>unknown</u> College (1-4 or 5+) <u></u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Carpenter</u> | | 16b. Kind of Business/Industry
<u>State Government</u> | | 17. Father's Name (First, Middle, Last)
<u>William Ridgley</u> | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Emma Hungerford</u> | | 19a. Informant's Name/Relationship (Type, Print)
<u>Alice Ridgley/Daughter</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>4449 Centennial Lane Ellicott City, MD 21042</u> | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Meadowridge Cemetery</u> | | 20c. Date
<u>1-30-97</u> | | 20d. Location - City or Town, State
<u>Elkridge, Maryland</u> | | 21. Signature of Funeral Service Licensee
<u>Sam A. Collins-Witzke</u> | |
| | 22. Name and Address of Facility
<u>Harry H. Witzke Funeral Home, Inc.</u>
<u>4112 Old Columbia Pike Ellicott City, MD 21043</u> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. <u>Emphysema (end stage)</u>
Due to (or as a consequence of):
b. <u>Coronary artery disease</u>
Due to (or as a consequence of):
c. <u></u>
Due to (or as a consequence of):
d. <u></u>
Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 23c. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 23d. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
<u></u> | | 28b. Time of Injury
<u></u> M <u></u> | |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
<u></u> | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
<u></u> | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier
<u>[Signature]</u> MD | | 29c. License number
<u>D42187</u> | | 29d. Date signed (Month, Day, Year)
<u>JAN 28, 1997</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>JAMES DAY 11055 Little Patuxent Parkway Columbia MD 21044</u> | |
| State Registrar | 31. Date filed (Month, Day, Year)
<u>JAN 28 1997</u> | | 32. Registrar's Signature
<u>[Signature]</u> | | 33. Registrar's Title
<u></u> | | 34. Registrar's Office
<u></u> | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Amended #12, 2/3/97
Add, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04276

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | |
|--|---|--|--|--------------------------|--|---|--------------------------------|--|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Thomas L. Rudd Sr. | | | | 2. Date of Death
Month Day Year
JANUARY 30 1997 | | | | 3. Time of Death
9:30AM | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Sacred Heart Hospital | | | | 4b. City, Town, or Location of Death
Cumberland | | | | 4c. County of Death
Allegany | | | | | | | |
| Funeral
Director | 5. Social Security Number
214-07-0526 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
102 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | 8. Date of Birth
(Month, Day, Year)
Oct 19, 1894 | | 9. Birthplace (State or Foreign Country)
VA | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| | 10e. Street and Number
771 Fayette Street | | | | 10f. Zip Code
21502 | | | | 10g. Citizen of What Country?
USA | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW IZ | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 18a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Factory Supervisor | | | | 16b. Kind of Business/Industry
Tire Company | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Douglas Rudd | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Belle (Powers) | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Thomas Rudd-son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1015 Van Buren Avenue Cumberland MD 21502 | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rose Hill Cemetery | | | | Date
02/01 | | 20c. Location - City or Town, State
Cumberland, MD | | | | | |
| | 21. Signature of Funeral Service Licensee
Nicholas J. Scarpelli | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Carcinomatosis
Due to (or as a consequence of):
b. Cancer of the Colon
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | | | | Approximate Interval Between Onset and Death
1 yr
2 yrs | |
| | Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | | | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury
(Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | |
| | 29b. Signature and title of certifier
Waples Spigler | | | | 29c. License number
D11443 | | | | 29d. Date signed (Month, Day, Year)
1-30-97 | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
912 Seton Dr. Cumberland MD 21502 | | | | | | | | | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 03 1997 | | | | 32. Registrar's Signature
Julia Anderson-Randall | | | | | | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

97 04277

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|-------------------------------------|---|--|--|--|--|--|--|--|--|---|--------------|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HURSEY EARL STEWART | | | | 2. Date of Death
Month Day Year
JAN. 26, 1997 | | | | 3. Time of Death
1406 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
3619 SOUTH HANOVER STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
N/A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
212-42-1769 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
53 | | 8. Date of Birth (Month, Day, Year)
SEPT. 20, 1943 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
3619 SOUTH HANOVER STREET | | | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U. S. A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
8 Elementary/Secondary (0-12) College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CRANE OPERATOR | | | 16b. Kind of Business/Industry
BETHLEHEM STEEL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
HARRY EARL STEWART | | | | 18. Mother's Name (First, Middle, Maiden Surname)
GLADYS ARBOUGH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
NAYWSA FITZ | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1313 CEARFOSS AVENUE, MARTINSBURG, WV 25401 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
ROSEDALE CEMETERY | | Date
2/1/97 | | 20c. Location - City or Town, State
MARTINSBURG, WV | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
Charles M. Brown | | | | 22. Name and Address of Facility
BROWN FUNERAL HOME, 327 W. KING STREET
PO BOX 821, MARTINSBURG, WV 25401 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="10">a. EMPHYSEMA</td> </tr> <tr> <td colspan="10">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="10">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="10">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="10">d. Due to (or as a consequence of):</td> </tr> </table> | | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. EMPHYSEMA | | | | | | | | | | Due to (or as a consequence of): | | | | | | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | | | | | | | | | | c. Due to (or as a consequence of): | | | | | | | | | | d. Due to (or as a consequence of): | | | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. EMPHYSEMA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
INSPECTION
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29c. License number
O.C.M.E | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
JAN. 26, 1997 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. ANN DIXON M.D. 111 PENN STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
John Davidson Randall | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04278

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BETTY JANE SPARKS | | | | 2. Date of Death
Month Day Year
February 1 1997 | | 3. Time of Death
0400 | |
| | 4a. Facility Name (If not institution, give street and number)
108 Buena Vista Ave. | | | | 4b. City, Town, or Location of Death
Cambridge | | 4c. County of Death
Dorchester | |
| Funeral
Director | 5. Social Security Number
220-28-0872 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
62 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 28 1934 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
MD | | 10b. County
Dorchester | | 10c. City, Town or Location
Cambridge | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
108 Buena Vista Ave. | | 10f. Zip Code
21613 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
button operator | | 16b. Kind of Business/Industry
garment manufacturing | | | |
| | 17. Father's Name (First, Middle, Last)
Robert Calvin Wheeler | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Marjorie Elzey | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Francis X. Sparks - husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
108 Buena Vista Ave., Cambridge MD 21613 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dorchester Memorial Park | | 20c. Date
2-4 | | 20d. Location - City or Town, State
Cambridge Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Kenneth R. Thomas Jr. | | | | 22. Name and Address of Facility
Thomas Funeral Home PA
700 Locust St. Cambridge MD 21613 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Respiratory Failure
Due to (or as a consequence of):
b. Lung metastases
Due to (or as a consequence of):
c. Small Cell Lung Cancer
Due to (or as a consequence of):
d. _____ | | | | Approximate Interval Between Onset and Death
6 wk
6 wk
6 wk | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Craig W. Caldwell | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
D33622 | | | | 29d. Date signed (Month, Day, Year)
02-3-97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Craig W. Caldwell, M.D. 2 Aurora Street, Cambridge, Maryland 21613 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
FEB 4 1997 | | | | 32. Registrar's Signature
John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04279

Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN DOUGLAS Sapulos | | 2. Date of Death
Month January Day 31 Year 1997 | | 3. Time of Death
1310 |
| | 4e. Facility Name (If not institution, give street and number)
PENINSULA REGIONAL MEDICAL CENTER | | 4b. City, Town, or Location of Death
SALISBURY | | 4c. County of Death
WICOMICO |
| Funeral
Director | 5. Social Security Number
217-28-3701 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
FEB. 3 1932 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
Somerset | | 10c. City, Town or Location
Marion Station | |
| 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 10a. Street and Number
4030 Back Shelltown Rd. | | 10f. Zip Code
21838 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: KOREA | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
letter carrier | | 16b. Kind of Business/Industry
U.S. Postal Service | |
| 17. Father's Name (First, Middle, Last)
George John Sapulos | | | 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Estelle Bennett | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Faith Cannon - daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4030 Back Shelltown Rd., Marion Station MD 21838 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Spedden-Seward Cemetery | | 20c. Location - City or Town, State
Cambridge, Maryland | |
| 21. Signature of Funeral Service Licensee
Kenneth R. Thomas Jr. | | 22. Name and Address of Facility
Thomas Funeral Home PA
700 Locust St. Cambridge MD 21613 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute Leukemia
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | Approximate Interval Between Onset and Death
7 yr |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
David C. O'Connell, MD | | 29c. License number
D26278 | | 29d. Date signed (Month, Day, Year)
1-31-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David C. O'Connell, MD 145E. Carroll St. Salisbury, MD 21801 | | | | | |
| 31. Date filed (Month, Day, Year)
EEB 3 1997 | | 32. Registrar's Signature
John Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04280

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth L. Swanger Sr.

2. Date of Death

JANUARY 30, 1997

3. Time of Death

1500

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

220-30-7853

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 15, 1934

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10e. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13500 Uhl Highway

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1953-9413. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Retired

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Gilbert W. Swanger

18. Mother's Name (First, Middle, Maiden Surname)

Lena N. (Jarvis)

19a. Informant's Name/Relationship (Type, Print)

Shirley Swanger-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13500 Uhl HW P.O. Box 2101 Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rocky Gap Veterans Cem

Date

02/03

20c. Location - City or Town, State

Flintstone, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home
Cumberland, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Renal failure

Due to (or as a consequence of):

b.

Chronic, portal hypertension

Due to (or as a consequence of):

c.

Hepatitis C

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

1 week

10 years

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pancreatitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)Extended care
unit

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. George Breza MD

29c. License number

D12532

29d. Date signed (Month, Day, Year)

JAN/31/97

30. Name and address of person who completed Cause of death (Item 23a) (Type, Print)

BREZA, GEORGE, M.D. 912 SETON DRIVE CUMBERLAND, MD. 21502

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

John Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04281

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD SWAN

2. Date of Death

Month Day Year

FEBRUARY 02, 1997

3. Time of Death

0004

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick Calvert

4c. County of Death

Prince Frederick Calvert

5. Social Security Number

579-20-4371

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 5 1924

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 2 Box 5

10f. Zip Code

20622

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year(s)

1965-1968

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Brick Layer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

James Vernal Swan

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite E. Strasburg Pinn

19a. Informant's Name/Relationship (Type, Print)

Dawn Hamilton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12505 Hamilton Acres Charlotte Hall, MD 20622

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cem.

Date

2/5/97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

David C. Echols MO0945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, INC.
P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2-3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Anwar Munshi M.D.

29c. License number

D 19427

29d. Date signed (Month, Day, Year)

2-2-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anwar Munshi M.D. Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

FEB 04 1997

32. Registrar's Signature

John Davidson Randall

State Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04282

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dresden Louie Rae Spencer

2. Date of Death

Month

Day

Year

Jan 27 1997

3. Time of Death

8:07 AM

4a. Facility Name (If not institution, give street and number)

The John Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

601-25-2524

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

4

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 14, 1992 Arizona

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland Pr. Georges

Landover

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

604 Tweed Way

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

0

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

David L. Spencer

18. Mother's Name (First, Middle, Maiden Surname)

Cecily Laurel Woodard

19a. Informant's Name/Relationship (Type, Print)

David L. Spencer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

604 Tweed Way Landover, MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Hills Memo. Park

Data

2/4/97

20c. Location - City or Town, State

Portland, Oregon

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home

9013 Annapolis Rd. Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

FUNGAL SEPSIS

5 DAYS

Due to (or as a consequence of):

NEUTROPENIA

4 WEEKS

Due to (or as a consequence of):

ACUTE LYMPHOBLASTIC LEUKEMIA

2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TRISOMY 21

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George K. Siberry MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

1/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE K SIBERRY DEPARTMENT OF PEDIATRICS, HOPKINS HOSPITAL, 600 N WOLFE ST

31. Date filed (Month, Day, Year)

FEB 11 1997

32. Registrar's Signature

John M. [Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04283

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last)

Agnes M. Schweitzer

2. Date of Death

Jan. 29, 1997

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

13905 Westview Forest Dr.

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

220 22 9541

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 31, 1906

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

13905 Westview Forest Drive

10f. Zip Code

20720

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Richard F. Mahoney

18. Mother's Name (First, Middle, Maiden Surname)

Hanna G. Moore

19a. Informant's Name/Relationship (Type, Print)

Joellen Bailey Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13905 Westview Forest Drive Bowie Maryland 20720

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

1/30/97

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe degenerative osteoarthritis

Depression

Diabetes - adult onset

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rachel M. Alefion MD

29c. License number

D44156

29d. Date signed (Month, Day, Year)

1/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 Gallant Fox Lane #118 Bowie, MD 20715

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

John A. ...

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04284

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MRS. JEANNE M. SPRINGS

2. Date of Death

Month Day Year
JANUARY 17 1997

3. Time of Death

10:50 AM

4a. Facility Name (If not institution, give street and number)

Mariner Health Care of Greater Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

577-50-7583

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 5, 1926

9. Birthplace (State or Foreign Country)

Harrisburg, PA.

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Laurel

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

13803 Briarwood Dr. #1813

10f. Zip Code

20708

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

U.S. Labor Dept.

17. Father's Name (First, Middle, Last)

John Washington

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Peters

19a. Informant's Name/Relationship (Type, Print)

Anderson Springs/former husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13803 Briarwood Dr. #1813 Laurel, Md. 20708

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hooper Memorial F.H.

Date

1-23-97

20c. Location - City or Town, State

Harrisburg, PA.

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 Ninth St. N.W. Washington, D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

10 days.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SUPERIOR VENA CAVA SYNDROME; STATUS POST
CUA WITH RIGHT HEMIPARESIS; RECURRENT
INVASIVE ADENOCARCINOMA OF COLON

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24e. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

J. P. Marshall ATTENDING PHYSICIAN D16200

29c. License number

29d. Date signed (Month, Day, Year)

JANUARY 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. M. MACHIRAN, M.D., 720 MAIDEN CHOICE LA, CATONSVILLE, 21228

31. Date filed (Month, Day, Year)

JAN 28 1997

32. Registrar's Signature

John Anderson-Randall

State
Registrar

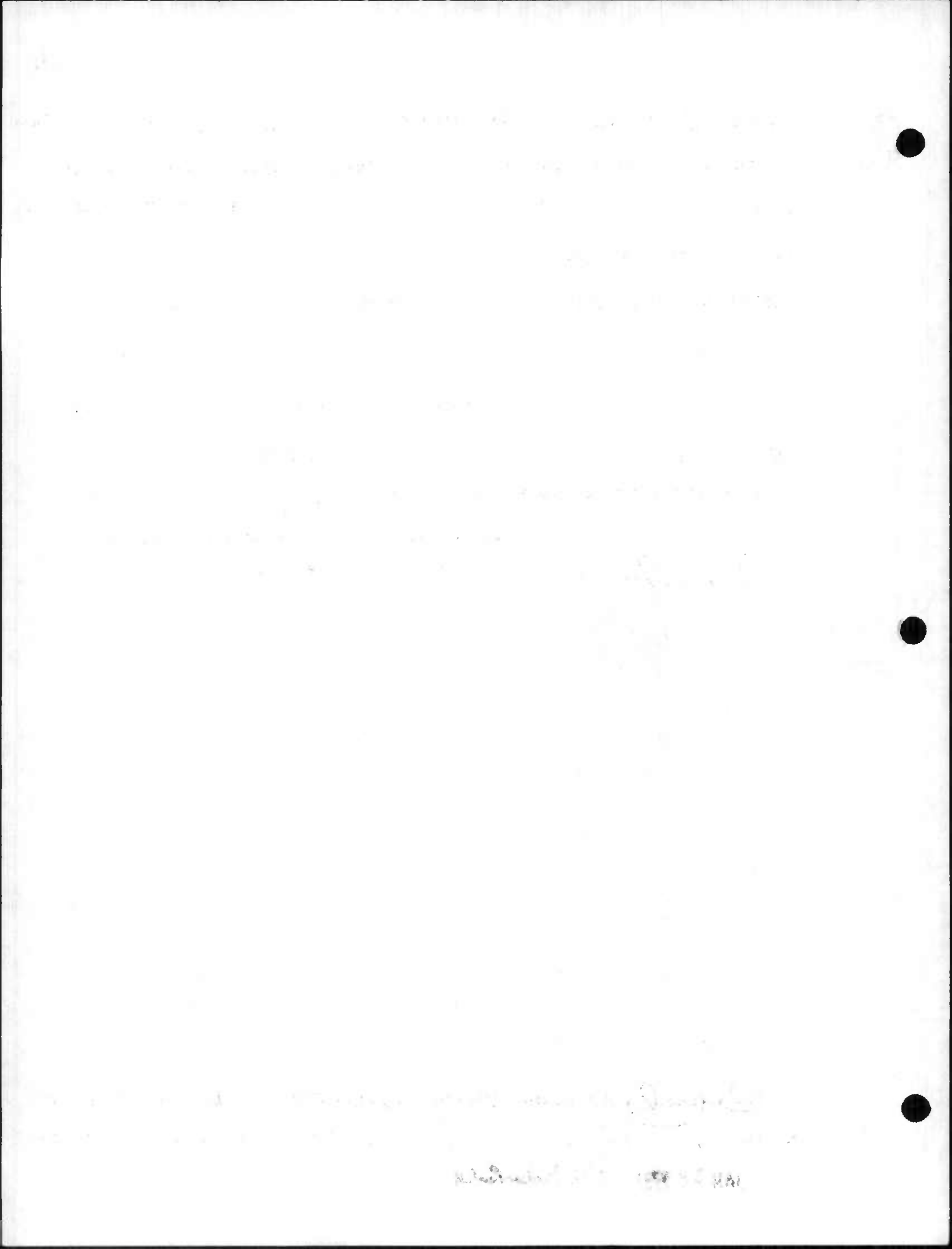
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04285

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|------------------------------------|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EDWARD JERONE SCRIVNER | | | | 2. Date of Death
Month Day Year
January 22 1997 | | 3. Time of Death
5:45P.M. |
| | 4a. Facility Name (If not Institution, give street and number)
Meade Village Circle | | | | 4b. City, Town, or Location of Death
Severn | | 4c. County of Death
Anne Arundel |
| Funeral
Director | 5. Social Security Number
579-88-1688 | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
24 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
March 11, 1972 | |
| | 9. Birthplace (State or Foreign Country)
Washington DC | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | |
| | 10a. State
Maryland | 10b. County
Anne Arundel | 10c. City, Town or Location
Glen Burnie | | | 10d. Inside City Limits
1 Yes 2 No | |
| | 10e. Street and Number
7889 Tall Pine Court #J | | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Restaurant Worker | | 16b. Kind of Business/Industry
Private | | |
| | 17. Father's Name (First, Middle, Last)
James Kimball | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Linda Scrivner | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Linda Scrivner/Mother | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7889 Tall Pine Court #J, Glen Burnie, MD 21061 | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | Date
1/27/97 | 20c. Location - City or Town, State
Landover, Maryland | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Nancy A. Perentie | | | 22. Name and Address of Facility
J. B. Jenkins Funeral Home
7474 Landover Road, Landover, Maryland 20785 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple gunshot wounds
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown |
| | 24a. Was an autopsy performed?
1 Yes 2 No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 Yes 2 No | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Street | | | | |
| | 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day, Year)
Found 1/22/97 | | 28b. Time of Injury
5:45PM | | 28c. Injury at Work?
1 Yes 2 No |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
sidewalk | | 28d. Describe how injury occurred
subject shot | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Meade Village in Anne Arundel County, Maryland | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | 29b. Signature and title of certifier
Theodore M. King MD | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
1/28/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201 | | | | | | |
| | 31. Date filed (Month, Day, Year)
JAN 29 1997 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

97 04286

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a, b, c, d, e, f per MEO G-744 **Certificate of Death**

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) WAYNE EDWARD SPEAK

2. Date of Death Month FEBRUARY 7, 1997 Day Year 1:55 P.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death FREDERICK

4c. County of Death FREDERICK

5. Social Security Number 213-38-1996

6. Sex 1 M 2 F

7. Age (In yrs. last birthday) 56 Yrs.

8. Date of Birth (Month, Day, Year) Nov 3, 1940

9. Birthplace (State or Foreign Country) Maryland

10a. State Maryland

10b. County Frederick

10c. City, Town or Location Frederick

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 8 James Street

10f. Zip Code 21701

10g. Citizen of What Country? U.S.A.

11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor

16b. Kind of Business/Industry Building Properties

17. Father's Name (First, Middle, Last) Clarence F

18. Mother's Name (First, Middle, Maiden Summa) Lillian Trail

19a. Informant's Name/Relationship (Type, Print) Candace C. Speak/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 James Street, Frederick, Maryland 21701

20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory Feb 10, 1997

20c. Location - City or Town, State Smithsburg, Maryland

21. Signature of Funeral Service Licensee Keith Lynn Roberson

22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ELECTROCUTION AND MULTIPLE INJURIES

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) 2/7/97

28b. Time of Injury 1:00 P.M.

28c. Injury at Work? Yes No

28d. Describe how injury occurred subject got shocked and fell from ladder

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) motel

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1505 W. Patrick St. Frederick, Md.

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Stephen S. Radentz, M.D.

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) FEBRUARY 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) FEB 14 1997

32. Registrar's Signature John Davidson

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04287

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ernest E. Thorne Sr. | | | | 2. Date of Death
Month Jan Day 25 Year 97 | | 3. Time of Death
713pm | |
| | 4a. Facility Name (If not institution, give street and number)
Howard County Hospital | | | | 4b. City, Town, or Location of Death
Columbia | | 4c. County of Death
Howard | |
| Funeral
Director | 5. Social Security Number
217-20-5866 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
93 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug 15, 1903 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Ellicott City | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
3334 North Chatham Road Apt. F | | | | 10f. Zip Code
21042 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown
College (14 or 5+) College | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Construction Worker | | | 16b. Kind of Business/Industry
Construction | | |
| | 17. Father's Name (First, Middle, Last)
John Thorne | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Duckett | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Betty Thorne/Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3334 N. Chatham Rd Apt F Ellicott City, MD 21042 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Columbia Memorial Park | | Date
1-29-97 | 20c. Location - City or Town, State
Clarksville, Maryland | | |
| | 21. Signature of Funeral Service Licensee
Sandra Collins-Witzke | | | | 22. Name and Address of Facility
Harry H. Witzke Funeral Home, Inc.
4112 Old Columbia Pike Ellicott City, MD 21043 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Lung Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Perforated peptic ulcer
Due to (or as a consequence of):

Approximate interval Between Onset and Death
months | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Perforated peptic ulcer | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Sandra Collins-Witzke | | 29c. License number
D50776 | | 29d. Date signed (Month, Day, Year)
Jan 25 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven H. Eversten MD 4801 Dorsey Hall Drive Suite 201B Ellicott City | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 28 1997 | | 32. Registrar's Signature
John A. ... | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04288

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AGNES

TONIC

2. Date of Death

January 19, 1997

3. Time of Death

1:00 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4711 BERWYN HOUSE ROAD #414

4b. City, Town, or Location of Death

COLLEGE PARK

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

243-16-0184

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

APRIL 3, 1916

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

COLLEGE PARK

10d. Inside City Limits

XXX Yes 2 ☐ No

10e. Street and Number

4711 BERWYN HOUSE ROAD #414

10f. Zip Code

20740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PORTER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

DAVID TONIC

18. Mother's Name (First, Middle, Maiden Surname)

SUSIE TURNER

19a. Informant's Name/Relationship (Type, Print)

HARVEY TONIC/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1200 I STREET NE WASHINGTON D.C. 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LINCOLN CEMETERY

Date

1/25/97

20c. Location - City or Town, State

SUITLAND, MARYLAND

21. Signature of Funeral Service Licensee

K. M. C. Bluscoe-Tonic

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME
4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

6 months

Due to (or as a consequence of):

b. CRITICAL CALCIFIC AORTIC STENOSIS 2 years

Due to (or as a consequence of):

c. X

Due to (or as a consequence of):

d. X

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS OF LIVER DUE TO

ALCOHOL ABUSE.

ANEMIA DUE TO CIRRHOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier
K. M. C. Bluscoe-Tonic
29c. License number
D22910
29d. Date signed (Month, Day, Year)
JAN: 23rd, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASIF S. QADRI - 4700 BERWYN HOUSE RD, COLLEGE PARK MD 20746

31. Date filed (Month, Day, Year)

JAN 28 1997

Registrar's Signature

J. M. C. Bluscoe-Tonic

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04289

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN THOMAS

2. Date of Death

Month Day Year
1 24 97

3. Time of Death

12:00AM

4a. Facility Name (If not institution, give street and number)

Hyattsville Healthcare Center

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578-78-7467

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

07-02-61

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5203 Addison Road

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 3/17/80

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Leo Davis Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Jean Clark

19a. Informant's Name/Relationship (Type, Print)

Jean Davis/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5203 Addison Road, Capitol Heights, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cem.

Date

01/31

1997

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentie

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. AIDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. Gupta, MD

29c. License number

M 46398

29d. Date signed (Month, Day, Year)

01-24-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Gupta MD, 121 Congressional Ave # 409, Rockville, MD 20852

31. Date filed (Month, Day, Year)

JAN 29 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Items: 23 part I, 27 per ME0 G-745 3/4/97 re **Certificate of Death**

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERIC DENNARD THORNTON

2. Date of Death

JAN. 29, 1997

3. Time of Death

1710 P

4a. Facility Name (If not institution, give street and number)

7503 COURTNEY PL..

4b. City, Town, or Location of Death

Landover, Md.

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

212-19-6487

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

22

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-12-74

9. Birthplace (State or Foreign Country)

P.G.

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince Georges

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

7503 COURTNEY PL.

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Navar Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teller Market

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Kenneth L. Thornton

18. Mother's Name (First, Middle, Maiden Sumama)

Linda Lott

19a. Informant's Name/Relationship (Type, Print)

Linda Thornton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7503 COURTNEY PL. Landover, MD. 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial 2/6/97 Landover, MD.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Sarah Branch

22. Name and Address of Facility

B.K. HENRY Funeral Chapel, Inc., WASH. D.C.
420-H ST. N.E.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. RIGHT VENTRICULAR DYSPLASIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Theodore M. King MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JAN. 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore M. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 07 1997

32. Registrar's Signature

Julia Swanson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04291

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MADGE C. WAGNER | | 2. Date of Death
Month Day Year
FEBRUARY 7, 1997 | | 3. Time of Death
5:15 AM |
| | 4a. Facility Name (If not institution, give street and number)
MEDIPLEX | | 4b. City, Town, or Location of Death
GAITHERSBURG | | 4c. County of Death
MONTGOMERY |
| Funeral
Director | 5. Social Security Number
294 36 2867 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
85 Yrs. | 8. Date of Birth (Month, Day, Year)
SEPT. 18, 1911 | 9. Birthplace (State or Foreign Country)
OHIO |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
MONTGOMERY | 10c. City, Town or Location
MONTGOMERY VILLAGE | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
19437 BRASSIE PLACE #103 | | 10f. Zip Code
20879 | 10g. Citizen of What Country?
UNITED STATES | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SECRETARY | | 16b. Kind of Business/Industry
BAKING | | |
| | 17. Father's Name (First, Middle, Last)
Antonio Cacic | | 18. Mother's Name (First, Middle, Maiden Surname)
Mattia Radic | | |
| | 19a. Informant's Name/Relationship (Type, Print)
LYNN W. DAWSON, DAUGHTER | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19111 CANADIAN COURT, MONTGOMERY VILLAGE, MD. 20879 | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METROPOLITAN CREMATORY 2/8/97 | | 20c. Location - City or Town, State
ALEXANDRIA, VA. |
| | 21. Signature of Funeral Service Licensee
Muriel H. Barber | | 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME
P.O. BOX 5038, LAYTONSVILLE, MD. 20882 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA
Due to (or as a consequence of)
b. CEREBROVASCULAR ACCIDENT
Due to (or as a consequence of)
c. CONGESTIVE HEART FAILURE
Due to (or as a consequence of)
d. Atrial Fibrillation
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | |
| Approximate Interval Between Onset and Death
DAYS
MONTHS
YEARS
YEARS | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA
GLUCOSE INTOLERANCE | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year) | | | | | |
| 28b. Time of Injury
M | | | | | |
| 28c. Injury et Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 28d. Describe how Injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
G. J. A. B. B. | | | | | |
| 29c. License number
B30692 | | | | | |
| 29d. Date signed (Month, Day, Year)
FEBRUARY 7, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
BERREDI 15200 SHADY GROVE ROAD, ROCKVILLE, MARYLAND 20850 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 12 1997 | | | | | |
| 32. Registrar's Signature
John Davidson Randall | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

97 04292

Physician /Medical Examiner
1. Decedent's Name (First, Middle, Last)
CARLTON E. WINGFIELD
2. Date of Death
Month **January** Day **30** Year **1997** 3. Time of Death
1414 PM
4a. Facility Name (If not institution, give street and number)
DORCHESTER GENERAL HOSPITAL 4b. City, Town, or Location of Death
CAMBRIDGE 4c. County of Death
DORCHESTER
5. Social Security Number
231-48-4183 6. Sex
1 M **2** F 7. Age (in yrs. last birthday)
60 Yrs. 8. Date of Birth
Month **May** Day **28** Year **1936** 9. Birthplace (State or Foreign Country)
Virginia
10a. State
Maryland 10b. County
Dorchester 10c. City, Town or Location
Cambridge 10d. Inside City Limits
X Yes **2** No
10e. Street and Number
401 Willis Street 10f. Zip Code
21613 10g. Citizen of What Country?
US
11. Marital Status
1 Never Married **2** Married **3** Widowed **4** Divorced 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes **2** No 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes **2** No Specify: **White** 14. Race - American Indian, Black, White, etc.
Specify: **White**
15. Decedent's Education (Specify only highest grade completed)
10 16. Kind of Business/Industry
Lumber Mill 17. Father's Name (First, Middle, Last)
Joseph J. Wingfield, Sr. 18. Mother's Name (First, Middle, Maiden Surname)
Eva Dickinson
19a. Informant's Name/Relationship (Type, Print)
Patricia A. Wingfield Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
712 Academy Street Cambridge, Maryland 21613
20a. Method of Disposition
1 Burial **2** Cremation **3** Removal from State **4** Donation **5** Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)
East New Market Cemetery 20c. Location - City or Town, State
2/3/97 East New Market, MD
21. Signature of Funeral Service Licensee
Thomas Funeral Home, P.A. 22. Name and Address of Facility
700 Locust Street Cambridge, Maryland 21613
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Acute Myocardial Infarction Approximate Interval Between Onset and Death
10 min
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
24a. Was an autopsy performed?
1 Yes **2** No 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes **2** No
25. Was case referred to medical examiner?
1 Yes **2** No 26. Piece of Death (Check only one)
Hospital: **1** Inpatient **2** Outpatient **3** DOA Other: **4** Nursing Home **5** Residence **6** Other (Specify)
27. Manner of Death
1 Natural **2** Accident **3** Suicide **4** Homicide **5** Pending Investigation **6** Could not be determined 28a. Date of injury (Month, Day, Year)
M 28b. Time of injury
1 Yes **2** No 28c. Injury at work?
1 Yes **2** No 28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)
Michael P. Fadden MD PA 408 Byrn Street, Cambridge MD 21613
29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **2** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. Signature and title of certifier
29c. License number
29d. Date signed (Month, Day, Year)
FEB 3 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
31. Data filed (Month, Day, Year)
32. Registrar's Signature
State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04293

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|---|--|---------------------------|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mildred Pauline Wagoner | | | | 2. Date of Death
Month Jan Day 29 Year 1997 | | 3. Time of Death
3:10 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Cumberland Nursing Home | | | | 4b. City, Town, or Location of Death
Cumberland | | 4c. County of Death
Allegany | |
| Funeral
Director | 5. Social Security Number
216-22-7166 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
87 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours | 8. Date of Birth
(Month, Day, Year)
Jul 23, 1909 | 9. Birthplace (State or Foreign Country)
PA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Allegany | | 10c. City, Town or Location
Cumberland | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
913 Glenwood Street | | | | 10f. Zip Code
21502 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | |
| | 17. Father's Name (First, Middle, Last)
Howard Holiday | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Stella (Gleason) | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Robert Wagoner, Sr.---step-son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Route 36 Corriganville MD 21524 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Ashby Cemetery | | Date
02/01 | | 20c. Location - City or Town, State
Fort Ashby, WV | |
| | 21. Signature of Funeral Service Licensee
Nicholas J. Scarpelli | | | | 22. Name and Address of Facility
Scarpelli Funeral Home
Cumberland, MD 21502 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
CVA
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Approximate Interval Between Onset and Death
days. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
Peter J. Halmon MD | | | | 29c. License number
DO 4981 | | 29d. Date signed (Month, Day, Year)
Jan 29, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. B. HALMON 302 Schley St. Cumberland, MD 21502 | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 31 1997 | | | | 32. Registrar's Signature
John D. Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

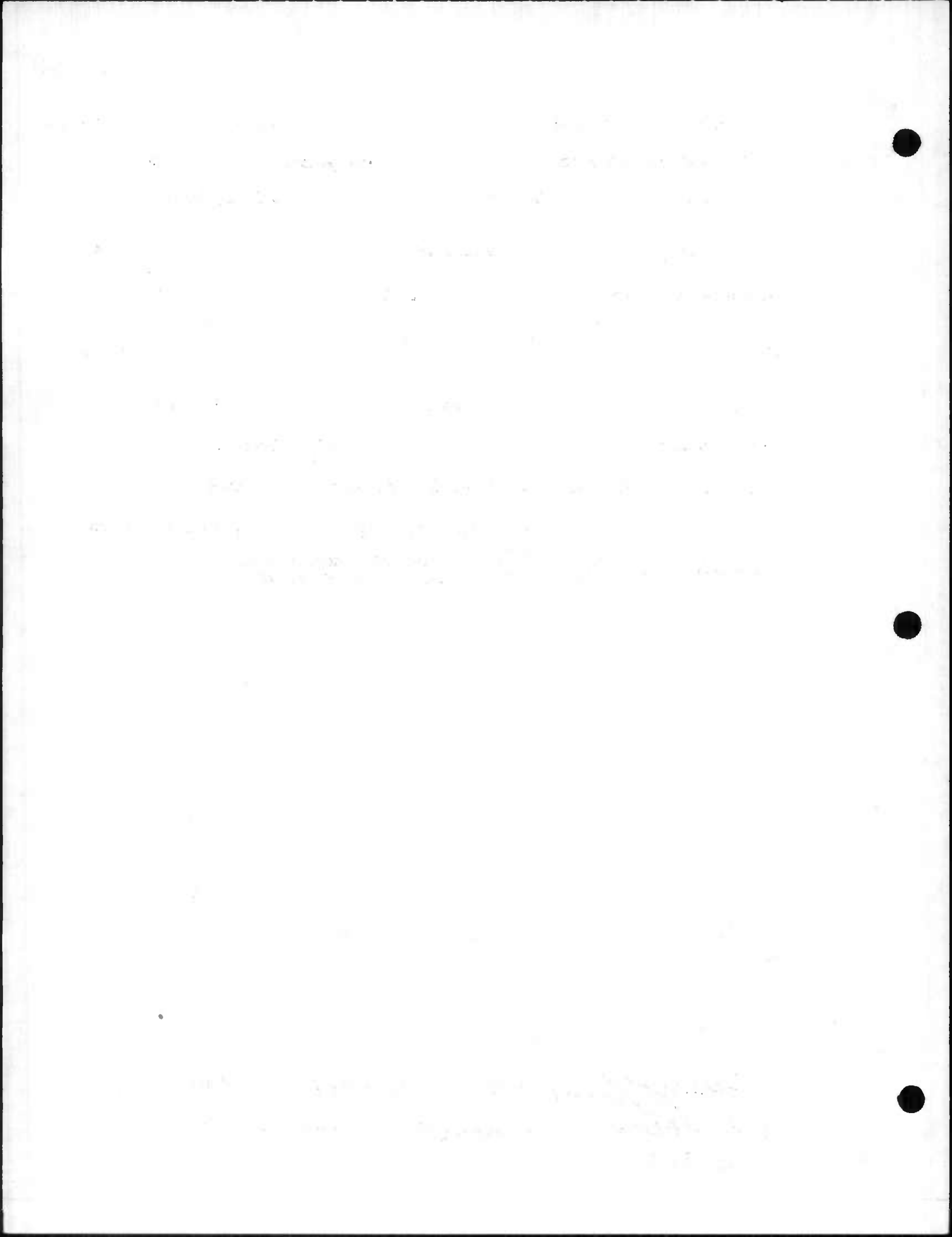
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6
DMS

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04294

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM D. WEBB JR.

2. Date of Death
Month Day Year

FEB 1 1997

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

931 WEIRES AVENUE

4b. City, Town, or Location of Death

LA VALE

4c. County of Death

ALLEGANY

Funeral
Director

5. Social Security Number

220-10-7456

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

AUG 14, 1919

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

LA VALE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

931 WEIRES AVENUE

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

FISCAL ACCOUNTING

16b. Kind of Business/Industry

ACCOUNTING

17. Father's Name (First, Middle, Last)

WILLIAM D. WEBB SR.

18. Mother's Name (First, Middle, Maiden Surname)

ESTELLA KYER

19a. Informant's Name/Relationship (Type, Print)

DELORES SKELLY WEBB

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

931 WEIRES AVE., LA VALE, MD 21502

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. AMBROSE CEMETERY

Date

FEB

20c. Location - City or Town, State

3, 1997 CRESAPTOWN, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HAFFER CHAPEL OF THE HILLS MORTUARY

1302 NATIONAL HWY, LA VALE, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Congestive Heart Failure*

Due to (or as a consequence of):

b. *Arteriosclerotic Cardiovascular Disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Cause of death
Addison's Disease
Post Abortion Prolactinoma - Seizure*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D13601

29d. Date signed (Month, Day, Year)

FEB-3-97

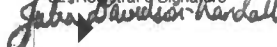
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. V R FELIPA, 925 BISHOP WALSH DR., CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

FEB 04 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04295

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Meredith Harvey Williams

2. Date of Death

January 29 1997

3. Time of Death

2241

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral
Director

5. Social Security Number

221-20-5683

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 6, 1933

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

201 Friendship Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates: 1951-1959

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Delmarva Power

17. Father's Name (First, Middle, Last)

Meredith E. Williams

18. Mother's Name (First, Middle, Maiden Surname)

Niomi Poole

19a. Informant's Name/Relationship (Type, Print)

Viola Williams/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

201 Friendship Road, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gracelawn Memorial Park

Date

2/1/97

20c. Location - City or Town, State

New Castle, Delaware

21. Signature of Funeral Service Licensee

Donald S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 W. Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Consumption coagulopathy

3 hrs

b.

Due to (or as a consequence of):

Ruptured aortic aneurysm

5 hrs

c.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald S. Hicks

29c. License number

D21578

29d. Date signed (Month, Day, Year)

1/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 Penn Ave 3D

Wilm Rd

19806

31. Date filed (Month, Day, Year)

FEB 03 1997

32. Registrar's Signature

Julia D. Wilson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11x10A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04296

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert

Wilkes

2. Date of Death

Month

Day

Year

January

29

1997

3. Time of Death

4:05 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

227-78-0009

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 10, 1955

9. Birthplace (State or Foreign Country)

Brunswick Co. VA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Prince George's

Capitol Heights

☒ Yes 2 ☐ No

10e. Street and Number

4202 Vine Street

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

African American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Legal Clerk

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Hayward Walker

18. Mother's Name (First, Middle, Maiden Surname)

Josie Mae Wilkes

19a. Informant's Name/Relationship (Type, Print)

Josie Mae Wilkes - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2006 Newcomb Street, Philadelphia, PA 19140

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Union R.Z.U.A. Church Cemetery 2/2/97

Date

20c. Location - City or Town, State

Meredithville, VA

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

AIDS.

Due to (or as a consequence of):

Meningitis.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

XIS.

days.

Immediate Cause (Final
disease or condition
resulting in death)Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tawakiah M.D.

29c. License number

D41978

29d. Date signed (Month, Day, Year)

1-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tawakiah M.D.

PGH. churms.

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

K. Anderson-Rodell

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04297

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John I. Witherspoon | | | | | | 2. Date of Death
Month Day Year
Jan. 13 1997 | | 3. Time of Death
9:55 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care Nursing Home | | | | | | 4b. City, Town, or Location of Death
Silver Spring | | 4c. County of Death
Montgomery | |
| Funeral
Director | 5. Social Security Number
579-16-3966 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 14, 1923 | | 9. Birthplace (State or Foreign Country)
Washington, DC | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
MD | | 10b. County
Montgomery | | 10c. City, Town or Location
Silver Spring | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
2501 Musgrove Rd. | | | | 10f. Zip Code
20901 | | 10g. Citizen of What Country?
USA | | | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11th College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Publications | | | 16b. Kind of Business/Industry
White House | | | |
| 17. Father's Name (First, Middle, Last)
John I. Witherspoon | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Martha Brown | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
William O. Witherspoon/Brother | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
956 Mt. Olivet Rd. NE #3 Wash, DC. 20002 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Park | | 20c. Location - City or Town, State
1-21-97 Landover, Md. | | | | |
| 21. Signature of Funeral Service Licensee
J. P. Marshall | | | | 22. Name and Address of Facility
Marshall's Funeral Home, Inc.
4217 9th St. N.W. Washington, DC 20011 | | | | | | |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. Cerebrovascular accident
Due to (or as a consequence of):</p> <p>b. Pneumonia
Due to (or as a consequence of):</p> <p>c.
Due to (or as a consequence of):</p> <p>d.
Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>1 month</p> <p>1 month</p> </div> </div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
Paul Armstrong MD | | 29c. License number
043237 | | 29d. Date signed (Month, Day, Year)
1 22 97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Armstrong 14201 Laurel PK Dr #102 Laurel MD 20707 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 28 1997 | | | | 32. Registrar's Signature
J. P. Marshall | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04298

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Jean White

2. Date of Death

January 26, 1997

3. Time of Death

11:46am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

578-54-7997

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 30, 1939

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1021 Stoddert Avenue

10f. Zip Code

20602

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Statistical Data Specialist

16b. Kind of Business/Industry

Statistics

17. Father's Name (First, Middle, Last)

Charles Hawkins

18. Mother's Name (First, Middle, Maiden Surname)

Rosetta Johnson

19a. Informant's Name/Relationship (Type, Print)

Charles White/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1021 Stoddert Avenue, Waldorf, Maryland 20602

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

1-31-97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, Maryland 2072223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CEREBRAL VASCULAR ACCIDENT

Approximate
Interval Between
Onset and Death

1 DAY

Due to (or as a consequence of):

HYPERTENSION

YEARS

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D - 50350

29d. Date signed (Month, Day, Year)

JANUARY 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank Kriger, MD 7C Post Office Road, Waldorf, Maryland 20602

31. Date filed (Month, Day, Year)

JAN 29 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04299

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|--|--|--------------------------|---|--|---|---|---|---|---------------|--|-----------------|----|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Ida Virginia Wall</u> | | | | 2. Date of Death
Month <u>Jan.</u> Day <u>26</u> Year <u>1997</u> | | 3. Time of Death
<u>5:32 A.M.</u> | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Crofton Convalescent Center</u> | | | | 4b. City, Town, or Location of Death
<u>Crofton</u> | | 4c. County of Death
<u>Anne Arundel</u> | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
<u>577 01 1620</u> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>95</u> Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Days | 8. Date of Birth
(Month, Day, Year)
<u>Aug. 18, 1901</u> | 9. Birthplace (State or Foreign Country)
<u>Washington D.C.</u> | | | | | | | | | |
| | Usual Residence of Decedent | | 10a. State
<u>Maryland</u> | | 10b. County
<u>Anne Arundel</u> | | 10c. City, Town or Location
<u>Crofton</u> | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
<u>1647 Forest Hill Court</u> | | 10f. Zip Code
<u>21114</u> | | 10g. Citizen of What Country?
<u>United States</u> | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Homemaker</u> | | 16b. Kind of Business/Industry
<u>Own Home</u> | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
<u>William Mudd</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Annie Hurley</u> | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>Mary A. Dixon Daughter</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>1647 Forest Hill Court Crofton Maryland 21114</u> | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Metropolitan Crematory</u> | | Date
<u>1/28/97</u> | | 20c. Location - City or Town, State
<u>Alexandria Virginia</u> | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
<u>Robert E. Evans Pres</u> | | 22. Name and Address of Facility
<u>Robert E. Evans Funeral Home, P.A.</u>
<u>16000 Annapolis Rd. Bowie Maryland 20715</u> | | | | | | | | | | | | | | |
| | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Dehydration</u>
Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death
<u>1 week</u></td> </tr> <tr> <td>b. <u>Dysphagia</u>
Due to (or as a consequence of):</td> <td><u>1 week</u></td> </tr> <tr> <td>c. <u>Dementia</u>
Due to (or as a consequence of):</td> <td><u>10 years</u></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. <u>Dehydration</u>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
<u>1 week</u> | b. <u>Dysphagia</u>
Due to (or as a consequence of): | <u>1 week</u> | c. <u>Dementia</u>
Due to (or as a consequence of): | <u>10 years</u> | d. | |
| | Immediate Cause (Final disease or condition resulting in death) | a. <u>Dehydration</u>
Due to (or as a consequence of): | Approximate Interval Between Onset and Death
<u>1 week</u> | | | | | | | | | | | | | | |
| b. <u>Dysphagia</u>
Due to (or as a consequence of): | | <u>1 week</u> | | | | | | | | | | | | | | | |
| c. <u>Dementia</u>
Due to (or as a consequence of): | | <u>10 years</u> | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Parkinsonism</u> | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | | | | | | | | | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
<u>[Signature] MD</u> | | | | | | | | | | | | | | | | | |
| 29c. License number
<u>D 38958</u> | | | | | | | | | | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
<u>1/28/97</u> | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Daljeet Singh Sidhu MD, 1413 ANNAPOLIS ROAD #106, ODENTON MD 21113</u> | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>JAN 29 1997</u> | | | | | | | | | | | | | | | | | |
| 32. Registrar's Signature
<u>[Signature]</u> | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04300

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert D. Williams

2. Date of Death

Jan. 24 1997

3. Time of Death

3:45 pm

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579-84-0742

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 20, 1961

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

VA

10b. County

10c. City, Town or Location

Alexandria

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

917 NORTH VAN DORN ST., #201

10f. Zip Code

22304

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

GED

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAILROOM SUPERVISOR

16b. Kind of Business/Industry

KODAK PHOTO CO.

17. Father's Name (First, Middle, Last)

ROBERT WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

MARY TAYLOR

19a. Informant's Name/Relationship (Type, Print)

TERESA JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

917 NORTH VAN DORN ST., #201 Alexandria VA 22304

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

1/29/97 LANDOVER, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Cheryl Bice

22. Name and Address of Facility

ROBERT G. MASON FUNERAL HOME 1661 Goodhope Rd.
Washington, D. C. 20020 SE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acquired immune deficiency
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Syndrome years
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Touben

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Jan. 25 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Touben 8218 Wisconsin Ave Bethesda MD

31. Date filed (Month, Day, Year)

JAN 29 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04301

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES

WRIGHT

2. Date of Death

Month
JANDay
26Year
97

3. Time of Death

4:45 AM

4a. Facility Name (If not institution, give street and number)

Regency Nursing & Rehab. Center

4b. City, Town, or Location of Death

Forestville

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

129-05-2271

6. Sex

12 M 20 F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09/07/07

9. Birthplace (State or Foreign Country)

CAMDEN SC.

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

FORESTVILLE MD.

10d. Inside City Limits

15 Yes 20 No

10e. Street and Number

7420 marlboro pike

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROFESSIONAL DANCER

16b. Kind of Business/Industry

ACTING INDUSTRY

17. Father's Name (First, Middle, Last)

JAMES WRIGHT

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH KIRKLAND

19a. Informant's Name/Relationship (Type, Print)

LULA W. MAYHEW/niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

325 P ST. S.W. APT#313 WASH, DC. 20024

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NORTHERN VA. CREMATOR 1/27/97 arlington VA.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Leander Cole

22. Name and Address of Facility

TRI-STATE F.S 6234 3RD ST. N.W WASH DC.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMER'S DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William T. Tanner

29c. License number

D35206

29d. Date signed (Month, Day, Year)

JAN 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William T. TANNER, M.D. 11701 Livingston Road, Suite #101, Fort Washington, MD.

31. Date filed (Month, Day, Year)

JAN 30 1997

32. Registrar's Signature

John Anderson-Rodall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04302

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruth Inez Yates | | 2. Date of Death
Month January Day 28 Year 1997 | | 3. Time of Death
0500 |
| | 4e. Facility Name (If not institution, give street and number)
Union Hospital | | 4b. City, Town, or Location of Death
Elkton | | 4c. County of Death
Cecil |
| Funeral
Director | 5. Social Security Number
407-36-0931 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | 8. Date of Birth (Month, Day, Year)
Oct 22 1928 | 9. Birthplace (State or Foreign Country)
Kentucky |
| | Usual Residence of Decedent | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | 10b. County
Cecil | 10c. City, Town or Location
Colora | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 10e. Street and Number
462 Firetower Rd. | | 10f. Zip Code
21917 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: 1950 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Registered Nurse | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 16b. Kind of Business/Industry
Medical | | 17. Father's Name (First, Middle, Last)
David B. McDaniel | | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Hunter | | 19e. Informant's Name/Relationship (Type, Print)
Homer G. Yates/Husband | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P O Box 20 462 Firetower Rd Colora MD 21917 | | 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | |
| | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hopewell Cemetery Jan 30 1997 | | 20c. Location - City or Town, State
Port Deposit MD | | |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
R. T. Foard Funeral Home, P.A.
111 S Queen St. Rising Sun MD 21911 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death)
a. Auto myocardial infarction
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
1 h. | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Pneumonia
Due to (or as a consequence of): | | 10 days | | |
| | c. old CVA.
Due to (or as a consequence of): | | | | |
| | d. old M.I.
Due to (or as a consequence of): | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Ju-ru-Nan MD | | 29c. License number
D04823 | | 29d. Date signed (Month, Day, Year)
1/20/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
223 West main st. Elkton, Md 21921 | | | | | |
| 31. Date filed (Month, Day, Year)
JAN 30 1997 | | 32. Registrar's Signature
 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04303

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BYRON RIELLY

YATES

2. Date of Death
Month Day Year

JANUARY 28, 1997

3. Time of Death

6:00 P.M.

4a. Facility Name (If not institution, give street and number)

7615 NORTHERN AVE

4b. City, Town, or Location of Death

GLENDALE

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

577 46 7633

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 2, 1936

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Glenn Dale

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

7615 Northern Ave.

10f. Zip Code

20769

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 X Married

3 Widowed 4 Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

X Yes 2 No

If Yes, Give

Year or Dates: 56-58

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Gasmaker

16b. Kind of Business/Industry

Gas Company

17. Father's Name (First, Middle, Last)

William Brook Yates

18. Mother's Name (First, Middle, Maiden Surname)

Marion M. Hook

19a. Informant's Name/Relationship (Type, Print)

Stephanie A. Yates Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2812 Bosworth Lane Bowie Maryland 20715

20a. Method of Disposition

X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery 2/3/97 Cheltenham Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Evans Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, P.A.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X No

25. Was case referred to medical examiner?

1 X Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes 2 X No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert E. Evans

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JANUARY 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryson D. Konou 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 31 1997

32. Registrar's Signature

John A. Ruffalo

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 5 2-19-97 Film G744 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04304

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOUGLAS KING BANKS

2. Date of Death

February 10th 1997

3. Time of Death

5:00 pm

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

235-28-2603

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 21, 1925

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Glen Gate Court

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Trucking Industry

17. Father's Name (First, Middle, Last)

Benjamin Banks

18. Mother's Name (First, Middle, Maiden Surname)

Annie King

19a. Informant's Name/Relationship (Type, Print)

Zelda P. Banks (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Glen Gate Court, Bel Air, MD. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

2/13/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

minutes

Due to (or as a consequence of):

b. Renal Failure

1 week

Due to (or as a consequence of):

c. Acute myelogenous leukemia

13 months

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

multiple myeloma

Liver Failure

Sept 1997

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Walker M.D. Union Memorial Hospital Baltimore, MD 21218

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04305

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
David Allender | | | | 2. Date of Death
Month February Day 10 Year 1997 | | 3. Time of Death
06:15 am | |
| | 4a. Facility Name (If not institution, give street and number)
Greater Baltimore Medical Center | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-48-9866 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
49 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 6, 1947 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore County | | 10c. City, Town or Location
Towson | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
2212 Eastridge Road | | 10f. Zip Code
21093 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 yrs | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Dermatologist | | 16b. Kind of Business/Industry
Medicine | | 17. Father's Name (First, Middle, Last)
Carlton Reay Allender, Sr. | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Esther Virginia Long | | 19a. Informant's Name/Relationship (Type, Print)
Carl R. Allender, Jr. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2443 Springlake Drive, Timonium, Maryland 21093 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mill Creek Ch of Brethren | | 20c. Location - City or Town, State
2/14/97 Mill Creek, Virginia | | 21. Signature of Funeral Service Licensee
Martin D. Lawson | | 22. Name and Address of Facility
Mitchell-Wiedefeld Home
6500 York Road, Baltimore, Maryland 21212 | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Fulminate ulcerative colitis
Due to (or as a consequence of):
Sepsis
Due to (or as a consequence of):
Renal failure
Due to (or as a consequence of):
DIC | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HIV Positive | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year)
2/14/97 | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
John A. Covington, M.D. | |
| State Registrar | 29c. License number
D25910 | | 29d. Date signed (Month, Day, Year)
02/11/97 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John A. Covington, M.D. 6565 N. Charles Street - Suite 408 Baltimore MD 21204 | | | |
| | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
Lia Davidson-Rendell | | | | | |

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|--|---|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DOROTHA ASHE | | | | 2. Date of Death
Month FEB. Day 12 Year 1997 | | 3. Time of Death
2056 P | |
| | 4a. Facility Name (If not institution, give street and number)
1139 CHIPPER DR. | | | | 4b. City, Town, or Location of Death
Edgewood | | 4c. County of Death
HARFORD | |
| Funeral
Director | 5. Social Security Number
412-56-3976 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
63 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
JAN. 14, 1934 | | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Harford | 10c. City, Town or Location
Edgewood | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1139 Chipper Dr. | | | 10f. Zip Code
21040 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Navar Marriad <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 yrs College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | | | |
| | 17. Father's Name (First, Middle, Last)
Samuel E. Trego, SR. | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lucy Wallace | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DONNA Airey / daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3304 Schuck St. Baltimore, Md 21224 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith | | 20c. Location - City or Town, State
Baltimore, Maryland | | 20d. Date
FEB. 17 1997 | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | | 22. Name and Address of Facility
Evans Chapel of Memories
8800 Harford Rd. Baltimore, Md 21234 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gastrointestinal hemorrhage
Due to (or as a consequence of):
b. Gastric ulceration
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
FEB. 13, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04307

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|--|---|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Alice L. Akehurst | | | | 2. Date of Death
Month Day Year
Feb. 5, 1997 | | 3. Time of Death
0554 | | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
220-07-5485 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month Day Year
Mar 29, 1920 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
2211 W. Rogers Avenue | | | | 10f. Zip Code
21209 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | | | |
| | 17. Father's Name (First, Middle, Last)
William Lewis | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carrie Shanklin | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
The Wesley Home | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2211 W. Rogers Avenue, Baltimore, Md 21209 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park Cemetery 2/8 | | 20c. Location - City or Town, State
Woodlawn, Maryland | | | | |
| | 21. Signature of Funeral Service Licensee
<i>Lynn Burgee-Henss</i> | | | | 22. Name and Address of Facility
Burgee-Henss Funeral Home 21211
3631 Falls Road, Baltimore, Maryland | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Cardio Vascular Disease
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c. Diabetes Mellitus
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure, | | | | | | | | |
| State Registrar | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>P. Filant, M.D.</i> | | | | 29c. License number
Dd1464 | | 29d. Date signed (Month, Day, Year)
2/13/97 | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
3508 Bank St BALD, MD 21224 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | 32. Registrar's Signature
<i>J. A. Davidson-Randall</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Freddie L. Bethea | | | | 2. Date of Death
Month 02 Day 11 Year 97 | | | | 3. Time of Death
23:13 | |
| | 4a. Facility Name (If not institution, give street and number)
University of Maryland Medical System | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
Baltimore City | |
| Funeral
Director | 5. Social Security Number
237-46-9654 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
63 Yrs. | | 8. Date of Birth (Month, Day, Year)
12-4-1933 | | 9. Birthplace (State or Foreign Country)
N.C. | |
| | Usual Residence of Decedent | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
3616 Marmon Avenue | | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
U.S.A | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Auto Mechanic | | | | 16b. Kind of Business/Industry
State Highway Admin. | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
George Bethea | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Ann | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Christine R. Bethea - wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3616 Marmon Avenue, Baltimore, MD 21207 | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Vet | | Date
2-18-97 | | 20c. Location - City or Town, State
Owings Mills, MD | | | |
| | 21. Signature of Funeral Service Licensee
Glynn B. Harris | | | | 22. Name and Address of Facility
March F.H. West 4300 Wabash Avenue Baltimore, MD 21215 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multi-system organ failure
Due to (or as a consequence of):
b. Sepsis
Due to (or as a consequence of):
c. Pneumonia
Due to (or as a consequence of):
d.
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
16 hours
30 hours
10 days | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 27e. Date of Injury (Month, Day, Year) | | 27b. Time of Injury
M | | 27c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 27d. Describe how Injury occurred | |
| | | | 27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 27f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| State Registrar | 29b. Signature and title of certifier
[Signature] | | | | 29c. License number
07995 | | 29d. Date signed (Month, Day, Year)
02/11/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
J. Sperry MD Dept of Surgery 22 South Greene St Baltimore MD 21201 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
[Signature] | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04309

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANTHONY BARTKOWIAK

2. Date of Death

Month 2 Day 12 Year 97

3. Time of Death

10:40am

4a. Facility Name (If not institution, give street and number)

808 DANZA ROAD

4b. City, Town, or Location of Death

SEVERN

4c. County of Death

A. A. CO.

Funeral
Director

5. Social Security Number

220-20-3840

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3-1-30

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MD.

10b. County

A.A. CO.

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

808 DANZA ROAD

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 49-50

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7 YEARS

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MAINTAINENCE

16b. Kind of Business/Industry

PIPE FITTER

17. Father's Name (First, Middle, Last)

LEONARD BARTKOWIAK

18. Mother's Name (First, Middle, Maiden Surname)

MARY SMITH

19a. Informant's Name/Relationship (Type, Print)

MRS. FRANCES OREM

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

808 DANZA RD. SEVERN, MARYLAND 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. STANISLAUS CEMETERY

Date

2-17-97

20c. Location - City or Town, State

BALTO. CITY MD.

21. Signature of Funeral Service Licensed

Charles R. Kaczorowski

22. Name and Address of Facility

KACZOROWSKI FUNERAL HOME

1201 DUNDALK AVE. BALTO. MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Small Cell Lung Cancer

Approximate Interval Between Onset and Death

9 months

Due to (or as a consequence of):

b. metastatic To Liver

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mayer Gorbatsky MD

29c. License number

027938

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mayer Gorbatsky MD 795 Aqueduct Rd. GB MD 21061

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

John Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04310

Certificate of Death

Reg. No.

| | | | | | | | |
|--|--|--|--|--|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOYCE BUTLER | | | 2. Date of Death
Month Day Year
FEB. 12, 1997 | | 3. Time of Death
1:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
216-48-4615 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
50 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
MAR 27, 1946 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | 10e. State
MARYLAND | | | | | | |
| To Be Completed by
Funeral Director | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
3951 GREENMOUNT AVE | |
| | 10f. Zip Code
21218 | | | 10g. Citizen of What Country?
USA | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | |
| To Be Completed by
Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 YEARS | | | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
REGISTERED NURSE | | 16b. Kind of Business/Industry
ST. JOSEPH MEDICAL CENTER | |
| To Be Completed by
Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
EUGENE Ringgold | | | 18. Mother's Name (First, Middle, Maiden Surname)
EDNA Speed | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mary Scott, Aunt | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
831 E. Quaker Bottom Road Sparks, Maryland 21152 | | | |
| To Be Completed by
Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Luke's U.M. Church Cem. | | 20c. Location - City or Town, State
HEREFORD, Maryland | |
| | 21. Signature of Funeral Service Licensee
Garry Harris | | | 22. Name and Address of Facility
CHATMAN - HARRIS Funeral Home
5240 REISTERSTOWN ROAD
BALTIMORE, MARYLAND 21215 | | | |
| To Be Completed by
Physician/Medical Examiner | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
BRAIN DEATH
ANOXIC ENCEPHALOPATHY
RESPIRATORY INSUFFICIENCY
HYPERTENSIVE HEART FAILURE | | | | | | Approximate Interval Between Onset and Death
2 DAYS
5 DAYS
5 DAYS
5 DAYS |
| | 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| To Be Completed by
Physician/Medical Examiner | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 28d. Describe how Injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
Richard Linthicum M.D. | | 29c. License number
P21826 | |
| To Be Completed by
Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)
2-13-97 | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
RICHARD LINTHICUM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | | |
| | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | 32. Registrar's Signature
Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

81

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04311

Items: 23 part I, 27, 28a, b, c, d, e, f per MEO G-744

2/20/97, reb.
Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES | | | | 2. Date of Death
FEB. 09, 1997 | | | | 3. Time of Death
1:26 PM. | | | |
| | 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | | | 4c. County of Death
N/A | | | |
| Funeral
Director | 5. Social Security Number
218-60-9810 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
42 Yrs. | | 8. Date of Birth (Month, Day, Year)
NOV. 21, 1954 | | 9. Birthplace (State or Foreign Country)
Maryland | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
4108 Wilke Ave. | | | | 10f. Zip Code
21206 | | | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
production worker | | | | 16b. Kind of Business/Industry
Halethorpe Extrusion | | | |
| | 17. Father's Name (First, Middle, Last)
Robert O. Bickenstaff | | | | 18. Mother's Name (First, Middle, Maiden Summa)
Charlotte J. Wolfe | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Alison Bickenstaff/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4108 Wilke Ave. Baltimore, Maryland 21206 | | | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel Inc. | | | | 20c. Location - City or Town, State
Baltimore, Maryland | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Evans Chapel of Memories | | | | 22. Name and Address of Facility
8800 Harford Rd. Baltimore, Md 21234 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
MEPERIDINE INTOXICATION | | | | | | | | | | Approximate Interval Between Onset and Death | |
| | Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
MEPERIDINE INTOXICATION | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | |
| | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 28a. Date of Injury (Month, Day, Year)
FOUND 2/9/97 | | | | | | | | | | 28b. Time of Injury
found unknown M | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | 28d. Describe how injury occurred
unknown | |
| State Registrar | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
found: residence | | | | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
4108 Wilke Ave. Baltimore, Md. | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | 29b. Signature and title of certifier
 | |
| DHM 16 Rev 6/95 | 29c. License number
O.C.M.E. | | | | | | | | | | 29d. Date signed (Month, Day, Year)
FEB. 10, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary Davis B. Kohnen | | | | | | | | | | 31. Date filed (Month, Day, Year)
FEB 14 1997 | |
| 32. Registrar's Signature
 | | | | | | | | | | | | |

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04312

Items: 23 part I, 27, 28a, b, c, d, e, f per MEO G-744 ^{12/26/97 reb} Certificate of Death

Reg. No.

| | | | | | |
|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CYRIL JOSEPH BUCKLEY | | 2. Date of Death
Month FEBRUARY Day 11 Year 1997 | | 3. Time of Death
8:30AM |
| | 4a. Facility Name (If not institution, give street and number)
3008 THORNDALE AVENUE | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA |
| Funeral
Director | 5. Social Security Number
083-44-5808 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
45 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
DEC. 27, 1951 | | 9. Birthplace (State or Foreign Country)
N.Y. | | |
| To Be Completed by Funeral Director | 10a. State
Md | | 10b. County
NA | | 10c. City, Town or Location
Baltimore |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
3008 Thorndale Avenue | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Welder | |
| 16b. Kind of Business/Industry
Bethlehem Steel | | 17. Father's Name (First, Middle, Last)
Cyril Buckley | | 18. Mother's Name (First, Middle, Maiden Surname)
Jennie Parris | |
| 19a. Informant's Name/Relationship (Type, Print)
Jennie Buckley - Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
754 N. Williams St Baldwin, N.Y. 11510 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Saints Cemetery | | 20c. Location - City or Town, State
2-18-97 Great Neck, N.Y. | |
| 21. Signature of Funeral Service Licensee
[Signature] | | 22. Name and Address of Facility
March 15 H. West 21215 4300 Wabash Avenue Baltimore | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a. ALCOHOL AND NARCOTIC INTOXICATION
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
| b. Due to (or as a consequence of): | | c. Due to (or as a consequence of): | | d. Due to (or as a consequence of): | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
Found 2/11/97 | | 28b. Time of Injury a.m.
found 8:25 | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
unknown | | 28e. Location (Street and Number or Rural Route Number, City or Town, State)
3008 Thorndale Ave. Baltimore, Md. | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and Title of Certifier
[Signature] | | 29c. License number
O.C.M.E. | |
| 29d. Date signed (Month, Day, Year)
FEBRUARY 11, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
[Signature] | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04313

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|--|--|--|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Joseph W. Brett</i> | | | | 2. Date of Death
Month <i>February</i> Day <i>11</i> Year <i>1997</i> | | 3. Time of Death
<i>5:15am</i> | | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Johns Hopkins Bayview Medical Center</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>N/A</i> | | |
| Funeral
Director | 5. Social Security Number
<i>164-58-7992</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>35</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>Aug. 17, 1961</i> | | |
| | 9. Birthplace (State or Foreign Country)
<i>Pennsylvania</i> | | 10a. State
<i>New Jersey</i> | | 10b. County
<i>Passiac</i> | | 10c. City, Town or Location
<i>Wayne</i> | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
<i>761 Alps Road</i> | | 10f. Zip Code
<i>07470</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12th grade</i>
College (1-4 or 5+) <i>College</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Health Aid</i> | | 16b. Kind of Business/Industry
<i>Health Care Industry</i> | | 17. Father's Name (First, Middle, Last)
<i>Richard Brett</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Maryann Price</i> | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>Donald D. Brett (Brother)</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>621 Cedar Lane, Bel Air, MD. 21015</i> | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Highview Mem. Gardens</i> | | 20c. Location - City or Town, State
<i>Fallston, Maryland</i> | |
| 21. Signature of Funeral Service Licensee
<i>Robert J. [Signature]</i> | | 22. Name and Address of Facility
<i>Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, MD. 21014</i> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<i>Cranial negative sepsis</i>
Due to (or as a consequence of):
<i>ARDS</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
<i>ARDS</i>
Due to (or as a consequence of):
<i>ARDS</i> | | Approximate Interval Between Onset and Death
<i>1 week</i>
<i>2 yrs</i> | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>Harold M.D.</i> | | 29c. License number
<i>D0051354</i> | | 29d. Date signed (Month, Day, Year)
<i>February 11, 1997</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>Johns Hopkins Bayview Medical Center</i> | | 31. Date filed (Month, Day, Year)
<i>FEB 14 1997</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04314

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THURMAN

E

BOHRER

2. Date of Death

FEB. 11 1997

Day

Year

3. Time of Death

01:30 P.M.

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare Center Heritage

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-10-3964

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 27, 1913

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3014 Mayfield Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automobile
Repair Shop

17. Father's Name (First, Middle, Last)

Jacob Bohrer

18. Mother's Name (First, Middle, Maiden Surname)

Laura Crouse

19a. Informant's Name/Relationship (Type, Print)

Gerald Bohrer (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3014 Mayfield Avenue, Baltimore, Maryland 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gardens of Faith Cemetery 2-15

Defe

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

CORONARY ARTERY DISEASE

Approximate
Interval Between
Onset and Death

5 YEARS

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastDue to (or as a consequence of):
CARCINOMA OF BLADDER

3 1/2 YEARS

Due to (or as a consequence of):
HYPOTHYROIDISM

1 MONTH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature] MD.

29c. License number

D14160 FEBRUARY 11, 1997

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (If not stated, leave blank)

HARJIT SINGH MD. 5410-A RITCHIE HIGHWAY, BALTIMORE,
MARYLAND - 21225

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed and filed by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04315

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie T. Bittman

2. Date of Death

February 7, 1997

3. Time of Death

8:00 A.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Parkside Assisted Living Inc.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

212-10-0749

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 3, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

815 Winters Lane Apt. 215

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Telephone Operator

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

John Vain

18. Mother's Name (First, Middle, Maiden Surname)

Anna Plsek

19a. Informant's Name/Relationship (Type, Print)

Otto Greul (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

426 Crosby Road, Baltimore, Maryland 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

2-10

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

THU

22. Name and Address of Facility

Schimunek Funeral Home

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. hypoxia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. chronic obstructive lung disease

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia, probable Alzheimer's-type

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) assisted living

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kris S. Kuhn MD

29c. License number

D37464

29d. Date signed (Month, Day, Year)

February 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRIS E. KUHN, MD. 3421 Benson Avenue Baltimore, Maryland 21227.

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Julia Davidson-Rondella

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04316

Certificate of Death


Reg. No.

| | | | | | | | | |
|--|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THERESA M BUSINSKY | | | | 2. Date of Death
Month Day Year
FEBRUARY 11, 1997 | | 3. Time of Death
01:45AM | |
| | 4a. Facility Name (If not institution, give street and number)
GREATER BALTIMORE MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
TOWSON | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
216-03-2015 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
84 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 26, 1912 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Baldwin | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 10e. Street and Number
4607 Carroll Manor Road | | 10f. Zip Code
21013 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
9th grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
Joseph Feinour | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
May V. Fitzer | | 19a. Informant's Name/Relationship (Type, Print)
Paul J. Businsky (husband) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4607 Carroll Manor Rd., Baldwin, MD 21013 | | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | |
| Physician
/Medical
Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Church Cem. | | 20c. Date
2/13/97 | | 20d. Location - City or Town, State
Hydes, Maryland | | 21. Signature of Funeral Service Licensed | |
| | 22. Name and Address of Facility
Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Congestive Heart Failure
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
± 1 yr | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | 23c. ASCVD
Due to (or as a consequence of): | | 23d. ± 1 yr | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | |
| State
Registrar | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Edward P Costlow MD | | 29c. License number
D19503 | | 29d. Date signed (Month, Day, Year)
2 11 97 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edward P Costlow MD 10 Gerard Ave 214 Timonium MD 21093 | | 31. Date signed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
John J. ... | | 33. Date signed (Month, Day, Year) | |
| | 34. Date signed (Month, Day, Year) | | 35. Date signed (Month, Day, Year) | | 36. Date signed (Month, Day, Year) | | 37. Date signed (Month, Day, Year) | |

97 04317

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH


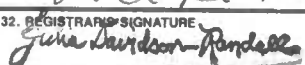
REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARY E. BOWSER | | | | 2. DATE OF DEATH
MONTH FEB DAY 10 YEAR 97 | | 3. TIME OF DEATH
1:45p | |
| 4. SOCIAL SECURITY NUMBER
191-12-8916 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
73 YRS. | 7. DATE OF BIRTH
(Month, Day, Year)
Dec. 5, 1923 | | 8. BIRTHPLACE (State or Foreign Country)
Pennsylvania | |
| 9a. FACILITY NAME (If not Institution, give street and number)
Deaton Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Edgewood | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1111 Hanson Road | | | | 10f. ZIP CODE
21040 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade
College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY
Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last)
David Plecher | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mary B. Withrow | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Terril R. Bowser (son) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1817 Twin Oak Road, Jarrettsville, MD 21084 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Holly Hill Mem'l Gardens | | DATE
2/13 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Schmunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, MD 21236 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → Urosepsis
DUE TO (OR AS A CONSEQUENCE OF): Dehydration

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF): | | | | | | Approximate Interval Between Onset and Death
12 day
12 day | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D34974 | | 29d. DATE SIGNED (Month, Day, Year)
2-10-97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
5865 Robert Oliver Rd # 121, Columbia, MD 21045 | | | | | | | |
| 31. DATE FILED
FEB 14 1997 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

RECEIVED

TO THE HEALTH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04318

Certificate of Death



Reg. No.

| | | | | | | | | |
|--|--|--|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GERALD A. BURLAGE | | | | 2. Date of Death
Month Day Year
FEBRUARY 12 1997 | | 3. Time of Death
1807 Hrs | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALISTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
311-28-7342 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 28, 1930 | |
| | 9. Birthplace (State or Foreign Country)
Indiana | | 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
Owings Mills | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Md | | | 10b. County
Baltimore | | | 10c. City, Town or Location
Owings Mills | | |
| 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 10e. Street and Number
5 Pleasant Ridge Dr. PH 12 | | | 10f. Zip Code
21117 | | |
| 10g. Citizen of What Country?
U.S.A. | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1954-1956 | | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 + 2 | | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Executive Producer | | | 16b. Kind of Business/Industry
Md. Public Television | | | 17. Father's Name (First, Middle, Last)
Gerald A. Burlage | | |
| 18. Mother's Name (First, Middle, Maiden Surname)
Lucy Elizabeth Bickel | | | 19a. Informant's Name/Relationship (Type, Print)
Dorothy Burlage | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Pleasant Ridge Dr. PH 12, Owings Mills, Md. 21117 | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Feb. 13, 1997 | | | 20c. Location - City or Town, State
Baltimore, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
Eckhardt Funeral Chapel
11605 Reisterstown Rd., Owings Mills, Md. 21117 | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. INTRACEREBRAL HEMORRHAGE
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | |
| 28a. Date of Injury (Month, Day, Year) | | | 28b. Time of Injury
M | | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 | | | 29c. License number
D37333 | | |
| 29d. Date signed (Month, Day, Year)
FEBRUARY 12, 1997 | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. RAVI MD, NHC, BALTO. MD 21133 | | | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | |
| 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04319

Item 6 2-18-97 Film G744 W.H.Per F/H

Item: 5, per F.H. G-744 2/21/97 reb

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|---|---|-----------------------------|---|--|--------------------------|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Anna Jane Behringer | | | 2. Date of Death
Month Day Year
Feb. 12, 1997 | | | 3. Time of Death
10:00 A.M. | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | 4b. City, Town, or Location of Death
Baltimore | | | 4c. County of Death
N/A | | | | |
| Funeral
Director | 5. Social Security Number
578-28-4291
218-22-3159 | | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
Aug. 2, 1924 | | 9. Birthplace (State or Foreign Country)
Maryland | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
MD. | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Odenton | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 10e. Street and Number
308 Nevada Avenue | | | | 10f. Zip Code
21113 | | | | 10g. Citizen of What Country?
U.S.A. | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6
College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | | |
| 17. Father's Name (First, Middle, Last)
George Albert Knott | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anna Mary Frimwalt | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
William W. Marszalek/Son | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
308 Nevada Avenue Odenton, Md. 21113 | | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Cemetery | | 20c. Location - City or Town, State
2-15-97 Elkridge, Maryland | | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Hardesty Funeral Home P.A.
851 Annapolis, Rd. Gambrills, Md. 21054 | | | | | |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Organ System Failure 2 days
Due to (or as a consequence of):
b. Cardiogenic Shock 3 days
Due to (or as a consequence of):
c. Acute Myocardial Infarction 4 days
Due to (or as a consequence of):
d. Chronic Ischemic Heart Disease 5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Bypass Surgery
Aortic Valve Replacement
Chronic Obstructive Lung Disease
Diabetes Mellitus - Hypothyroidism | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | | | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | 29b. Signature and title of certifier
 M.D. | | | 29c. License number
AT 2438946 | | 29d. Date signed (Month, Day, Year)
February 12, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SALIM I RIZK, MD. 201 East University Parkway Balto. Md. 21218 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | 32. Registrar's Signature
 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04320

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARGARET E. BURDETTE

2. Date of Death

FEBRUARY 7, 1997 6:58AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL ASSN GLEN BURNIE ANNE ARUNDEL

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

217-05-5961

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 31, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Hanover

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7627 Bear Forest Road

10f. Zip Code

21076

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Camden Lunch Room

17. Father's Name (First, Middle, Last)

George Sheppard

18. Mother's Name (First, Middle, Maiden Surname)

Mary Slaughter

19a. Informant's Name/Relationship (Type, Print)

Mary A. Shacka Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7627 Bear Forest Road Hanover, Maryland 21076

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakeview Mem. Park Feb. 10, 1997

Date

20c. Location - City or Town, State

Elversburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

2 HOURS

Due to (or as a consequence of):

b. DIABETES MELLITIS

10 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dan H. Schreiber, MD

29c. License number

D28221

29d. Date signed (Month, Day, Year)

FEBRUARY 9, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAN H. SCHREIBER, MD 301 HOSPITAL DRIVE GLENBURNIE MARYLAND 21061

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

21061

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within a hour after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04321

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS ANTHONY BESSENT

2. Date of Death

FEB. 9 1997

3. Time of Death

1:55 PM

4a. Facility Name (If not institution, give street and number)

3901 DARLEIGH ROAD #1A

4b. City, Town, or Location of Death

PERRY HALL

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

215-12-5597

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

12/1/20

9. Birthplace (State or Foreign Country)

W. VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PERRY HALL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3901 DARLEIGH ROAD #1A

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

MECHANICAL ENGINEER

16b. Kind of Business/Industry

BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)

CARL BISHOP BESSENT

18. Mother's Name (First, Middle, Maiden Surname)

EDITH J. FLOOD

19a. Informant's Name/Relationship (Type, Print)

CARL BESSENT

BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4405 NORWOOD ROAD BALTIMORE, MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

DULANEY VALLEY MEMORIAL

Date

2/12/97

20c. Location - City or Town, State

COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee

Christina R. Kopych

22. Name and Address of Facility

JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.

TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute intracerebral hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Crossman O'Jovan, M.D.

29c. License number

DO 7632

29d. Date signed (Month, Day, Year)

FEB. 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. CROSSMAN O'JOVAN, M.D., 2112 DUNDALK AVE., BALTO MD 21222

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Julia Davidson-Pondella

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04322

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Julius Bernstein

2. Date of Death

February 5 1997 4:15 PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Marys

Funeral
Director

5. Social Security Number

579-24-8078

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 23, 1916 New York

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Marys

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29449 Charlotte Hall Road

10f. Zip Code

20622

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 11/58

If Yes, Give Year or Dates: 6-1942-

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mail Carrier

16b. Kind of Business/Industry

Medical Care

17. Father's Name (First, Middle, Last)

Abraham Bernstein

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Bernstein

19a. Informant's Name/Relationship (Type, Print)

Peggy Sue Garner/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5213 Vaughan Ct., Waldorf, MD 20622

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e.

PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD, CHF, CAD S/P CABG

HTN, Multiple CVA, D/D

RIB FRACTURE 10th RIB @, SEIZURE P/O

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Julius P. Subban MD

29c. License number

D50963

29d. Date signed (Month, Day, Year)

2/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FULTON LUCBAN MD, CHNH, CHARLOTTE HALL, MD

State
Registrar

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Julius P. Subban

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04323

ITEM#6 PER FUNERAL HOME FLM#G744 2-18-97 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NICHOLAS JOHN BALZANO

2. Date of Death

FEBRUARY 09 1997 08:33 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-10-8271

6. Sex

M

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1-12-1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

408 W. 23rd Street

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Roofer

16b. Kind of Business/Industry

Commercial/Residential Roofing

17. Father's Name (First, Middle, Last)

Frank Balzano

18. Mother's Name (First, Middle, Maiden Surname)

Rose Matrangelo

19a. Informant's Name/Relationship (Type, Print)

Patricia Summers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2526 Lenore Street Parkersburg, WV 26101

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Park

Date

2/13/97

20c. Location - City or Town, State

Eldersburg, Maryland

21. Signature of Funeral Service Licensee

Lucy H. Carpenter

22. Name and Address of Facility

Burgee-Henss Funeral Home

3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MULTIPLE PULMONARY EMBOLI

Approximate Interval Between Onset and Death

2-3 hrs.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): CHRONIC PULMONARY ARTERY THROMBOSIS

WEEKS

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEEP VEIN THROMBOSIS, LEG
ADENOCARCINOMA OF THE PROSTATE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles C. Brown, MD - Assoc. Pathologist

29c. License number

DO 1008

29d. Date signed (Month, Day, Year)

FEB 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles C. Brown, MD. 201 E. UNIVERSITY PARKWAY - BALO., MD - 21218

31. Date filed (Month, Day, Year)

FEB 14 1997

Registrar

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97 04324

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Frank Baier | | | | 2. DATE OF DEATH
MONTH 2 DAY 10 YEAR 97 | | 3. TIME OF DEATH
3:35 P.M. | |
| 4. SOCIAL SECURITY NUMBER
213-01-5343 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 8. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
9-17-12 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Canton Harbor Healthcare | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | 9c. COUNTY OF DEATH
n/a | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
Md. | | 10b. COUNTY
Baltimore | | 10c. CITY, TOWN OR LOCATION
Eastpoint | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
8033 Lansdale Road | | | | 10f. ZIP CODE
21224 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (8-12) 7th College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Laborer | | 16b. KIND OF BUSINESS/INDUSTRY
Eastern Stainless Steel | |
| 17. FATHER'S NAME (First, Middle, Last)
John Baier | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Isabelle Lloyd | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Edith Baier / wife | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8033 Lansdale Road Baltimore Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 2/13/97 | | 20c. LOCATION — City or Town, State
Baltimore Md. | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
R. Terry Connelly | | | | 22. NAME AND ADDRESS OF FACILITY
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 21221 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
a. DUE TO (OR AS A CONSEQUENCE OF):
Severe Chronic Obstructive Lung Disease
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Calcium of lungs | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | |
| 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Patricia V. PATRICK | | | | 29c. LICENSE NUMBER
208358 | | 29d. DATE SIGNED (Month, Day, Year)
2/10/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
GRACIE V. PATRICK 703 S. CLINTON Street Balt. Md. 21224 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1997 | | | | 32. REGISTRAR'S SIGNATURE
Davidson | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68766,

RB

IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04325

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AGATHA CACHIA

2. Date of Death

FEB. 14 1997 5:00 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

201 RIDGE AVE

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

n/a

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 25, 1922

9. Birthplace (State or Foreign Country)

Malta

Usual Residence of Decedent

10e. State

n/a

10b. County

n/a

10c. City, Town or Location

Valletta, Malta

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

171 St. Dominic St.

#3

10f. Zip Code

VLT02

10g. Citizen of What Country?

Malta

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

n/a

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

Joseph

Zarb

18. Mother's Name (First, Middle, Maiden Surname)

Josephine

Portelli

19a. Informant's Name/Relationship (Type, Print)

Myriam Cachia / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

201 Ridge Rd., Towson, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Green Mount Crematory 2/15/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.

8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Breast Cancer

Approximate Interval Between Onset and Death

2 years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen D. Lohrmann

29c. License number

D45994

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DONALD E. CASEY JR MD 6 BMC

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

John Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04326

Certificate of Death

Reg. No.

| | | | | | |
|--|---|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Suntok Choi | | 2. Date of Death
Month: February Day: 10 Year: 1997 | | 3. Time of Death
4:47 PM |
| | 4a. Facility Name (If not institution, give street and number)
Maryland General Hospital | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
451-77-6773 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
45 Yrs. | If Under 1 Year
Months: Days: Hours: Min. | 8. Date of Birth
Month: March Day: 28 Year: 1951 |
| | Usual Residence of Decedent
10a. State: Maryland 10b. County: N/A 10c. City, Town or Location: Baltimore | | 10d. inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 9. Birthplace (State or Foreign Country)
Korea |
| To Be Completed by Funeral Director | 10e. Street and Number
2126 Maryland Ave. 3rd Floor | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Korean |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 College (14 or 5+): 10 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Reporter | | 16b. Kind of Business/Industry
Newspaper |
| | 17. Father's Name (First, Middle, Last)
unknown | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mr. Sang Gul Choi (Husband) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2126 Maryland Ave. 3rd Floor Balto. Md. 21218 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington Crematory | | 20c. Location - City or Town, State
2/13/97 Arlington Co. Va. |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gram Negative Sepsis
Due to (or as a consequence of):
b. Diabetes mellitus
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of): | | Approximate interval between Onset and Death | | |
| Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Khurram Butt | | 29c. License number
89267 | 29d. Date signed (Month, Day, Year)
2/11/97 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Khurram Butt, M.D. c/o Maryland General Hospital. | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
Davidson-Randall | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 04327

Items: 5, 6, 7 per F.H.G-744 2/14/97 reb Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
LEONARD W. COLLINS | | 2. Date of Death
Month FEBRUARY Day 12 Year 1997 | | 3. Time of Death
3:45AM | |
| 4a. Facility Name (If not institution, give street and number)
1448 HULL STREET | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| 5. Social Security Number
215-566-1189 | | 6. Sex
1XXM | | 7. Age (In yrs. last birthday)
90 80 Yrs. | |
| 8. Date of Birth
Month, Day, Year
MARCH 15, 1916 | | 9. Birthplace (State or Foreign Country)
MD | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City | |
| 10d. Inside City Limits
1XX Yes 2XX No | | | | | |
| 10e. Street and Number
1448 Hull Street | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1XX Never Married 2XX Married
3XX Widowed 4XX Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1XX Yes 2XX No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1XX Yes 2XX No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: white | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th
College (1-4 or 5+) N/A | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Truck Driver | | 16b. Kind of Business/Industry
Transportation | |
| 17. Father's Name (First, Middle, Last)
James Leonard Collins | | 18. Mother's Name (First, Middle, Maiden Surname)
Willie Ruth Burton | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Bonnie Koesters / Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1731 Patapoco Street, Baltimore, MD 21230 | | | |
| 20a. Method of Disposition
1XX Burial 2XX Cremation 3XX Removal from State
4XX Donation 5XX Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery Feb 15, 1997 | | 20c. Location - City or Town, State
Baltimore MD | |
| 21. Signature of Funeral Service Licensee
[Signature] | | 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Ave. Balto. MD 21230 | | | |

To Be Completed by Funeral Director

Physician
/Medical
Examiner

| | | | | | |
|--|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | e. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of): | | Approximate Interval Between Onset and Death | |
|--|--|---|--|--|--|

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | |
|---|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
1XX Yes 2XX No 3XX Probably 4XX Unknown | |
| 24a. Was an autopsy performed?
INSPECTED
1XX Yes 2XX No | | 24b. Were autopsy findings available prior to completion of cause of death?
1XX Yes 2XX No | |
| 25. Was case referred to medical examiner?
1XX Yes 2XX No | | 26. Place of Death (Check only one)
Hospital: 1XX Inpatient 2XX ER/Outpatient 3XX DOA Other: 4XX Nursing Home 5XX Residence 6XX Other (Specify) | |
| 27. Manner of Death
1XX Natural 2XX Accident 3XX Suicide 4XX Homicide
5XX Pending investigation 6XX Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M
28c. Injury at Work?
1XX Yes 2XX No | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. Signature and title of certifier
Donald G. Wright MD | | 29c. License number
O.C.M.E. | |
| 29d. Date signed (Month, Day, Year)
FEBRUARY 14, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201 | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
[Signature] | |

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04328

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Craft

2. Date of Death

February 12, 1997

3. Time of Death

3:03 AM

4a. Facility Name (If not institution, give street and number)

Villa St. Michael

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

230-12-7310

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB 9, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2131 Homewood Avenue

10f. Zip Code

21201

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Pastor

16b. Kind of Business/Industry

Methodist Church

17. Father's Name (First, Middle, Last)

Eddie Booker

18. Mother's Name (First, Middle, Maiden Surname)

Irene Fitzgerald

19a. Informant's Name/Relationship (Type, Print)

Janet Lola Draper/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 East Preston St., Apt. 120 Balto., MD 21202

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 2/13/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebral Thrombosis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

30 mins

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residencia6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tasneem Lakhani

29c. License number

D28595

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM LAKHANI 7220 PARK HEIGHTS AVE BALTO MD

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Tasneem Lakhani

21208

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Registrar/Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

James M. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04329

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|---------------------------------------|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ethel Sophia Cooper | | | | 2. Date of Death
Month February Day 13 Year 1997 | | 3. Time of Death
5:10 am | |
| | 4a. Facility Name (If not institution, give street and number)
Genesis ElderCare Loch Raven | | | | 4b. City, Town, or Location of Death
Baynesville | | 4c. County of Death
Baltimore Co. | |
| Funeral
Director | 5. Social Security Number
218-18-2330 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
96 Yrs. | | 8. Date of Birth (Month, Day, Year)
December 9, 1901 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore Co. | | 10c. City, Town or Location
Parkville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
3310 Putty Hill Road | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Insurance Company | | | |
| | 17. Father's Name (First, Middle, Last)
Charles Henry White | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sophia Birx | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mrs. Barbara J. Most/Personal Representative | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3310 Putty Hill Road Parkville, Maryland 21234 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify: Entombment) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lorraine Park Mausoleum | | Data
2/17/97 | | 20c. Location - City or Town, State
Woodlawn, Maryland | |
| | 21. Signature of Funeral Service Licensee
Brian A. Willem | | 22. Name and Address of Facility
Leonard J. Ruck Funeral Home, Inc.
5305 Harford Road Baltimore, Maryland 21214 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Dehydration
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c. Breast Mass (R)
Due to (or as a consequence of):
d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Trish Tripurani | | 29c. License number
D 30661 | | 29d. Date signed (Month, Day, Year)
February 14th 97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
5670 The Adameda, Baltimore, Md - 21239 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
Julie Davidson-Randall | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be attached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

97 04330

Reg. No.

| | | | | | | | | | | | | |
|--|--|---|---|--|--|--|---|--|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
NELLIE B. CHILES | | | | | 2. Date of Death
Month FEBRUARY Day 12 Year 1997 | | 3. Time of Death
6:15 P.M. | | | | |
| | 4a. Facility Name (If not institution, give street and number)
FREDERICK VILLA NURSING CENTER | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE | | | | |
| Funeral
Director | 5. Social Security Number
231-12-7632 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
JULY 29 1909 | | 9. Birthplace (State or Foreign Country)
WEST VIRGINIA | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 10e. Street and Number
2008 MOSBY LANE | | | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
USA | | | | | |
| 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOUSEKEEPING | | | 16b. Kind of Business/Industry
ALEXANDRIA HOSPITAL | | | | | |
| 17. Father's Name (First, Middle, Last)
JOHN C. ROSE | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
PRISCILLA LAKE | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
PHYLLIS BROWN/DAUGHTER | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2008 MOSBY AVENUE BALTIMORE, MARYLAND 21207 | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETHEL CEMETERY | | | Date
FEB 14 1997 | | 20c. Location - City or Town, State
ALEXANDRIA, VIRGINIA | | | | |
| 21. Signature of Funeral Service Licensee
 | | | | | 22. Name and Address of Facility
LOUDON PARK FUNERAL HOME
3620 WILKENS AVENUE BALTIMORE, MARYLAND 21229 | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td style="width:50%; vertical-align: top;"> <div style="font-size: 2em; margin-left: 100px;">Renal failure</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> <div style="font-size: 2em; margin-left: 100px;">8 weeks mellitus</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> <div style="font-size: 2em; margin-left: 100px;">1 Hypertension</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> </td> <td style="width:20%; vertical-align: top;"> Approximate Interval Between Onset and Death

 <div style="font-size: 1.5em;">6 year</div> <div style="font-size: 1.5em;">13 years</div> <div style="font-size: 1.5em;">13 years</div> </td> </tr> </table> | | | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | <div style="font-size: 2em; margin-left: 100px;">Renal failure</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> <div style="font-size: 2em; margin-left: 100px;">8 weeks mellitus</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> <div style="font-size: 2em; margin-left: 100px;">1 Hypertension</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> | Approximate Interval Between Onset and Death

<div style="font-size: 1.5em;">6 year</div> <div style="font-size: 1.5em;">13 years</div> <div style="font-size: 1.5em;">13 years</div> |
| Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | <div style="font-size: 2em; margin-left: 100px;">Renal failure</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> <div style="font-size: 2em; margin-left: 100px;">8 weeks mellitus</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> <div style="font-size: 2em; margin-left: 100px;">1 Hypertension</div> <div style="margin-left: 100px;">Due to (or as a consequence of):</div> | Approximate Interval Between Onset and Death

<div style="font-size: 1.5em;">6 year</div> <div style="font-size: 1.5em;">13 years</div> <div style="font-size: 1.5em;">13 years</div> | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | | 29c. License number
022114 | | 29d. Date signed (Month, Day, Year)
February 12, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DAMIAN E. BERCHESS MD
5411 OLD FREDERICK ROAD, SUITE 18, BALTO, MD 21229 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | 32. Registrar's Signature
 | | | | | | | | | |

To Be Completed by Funeral Director

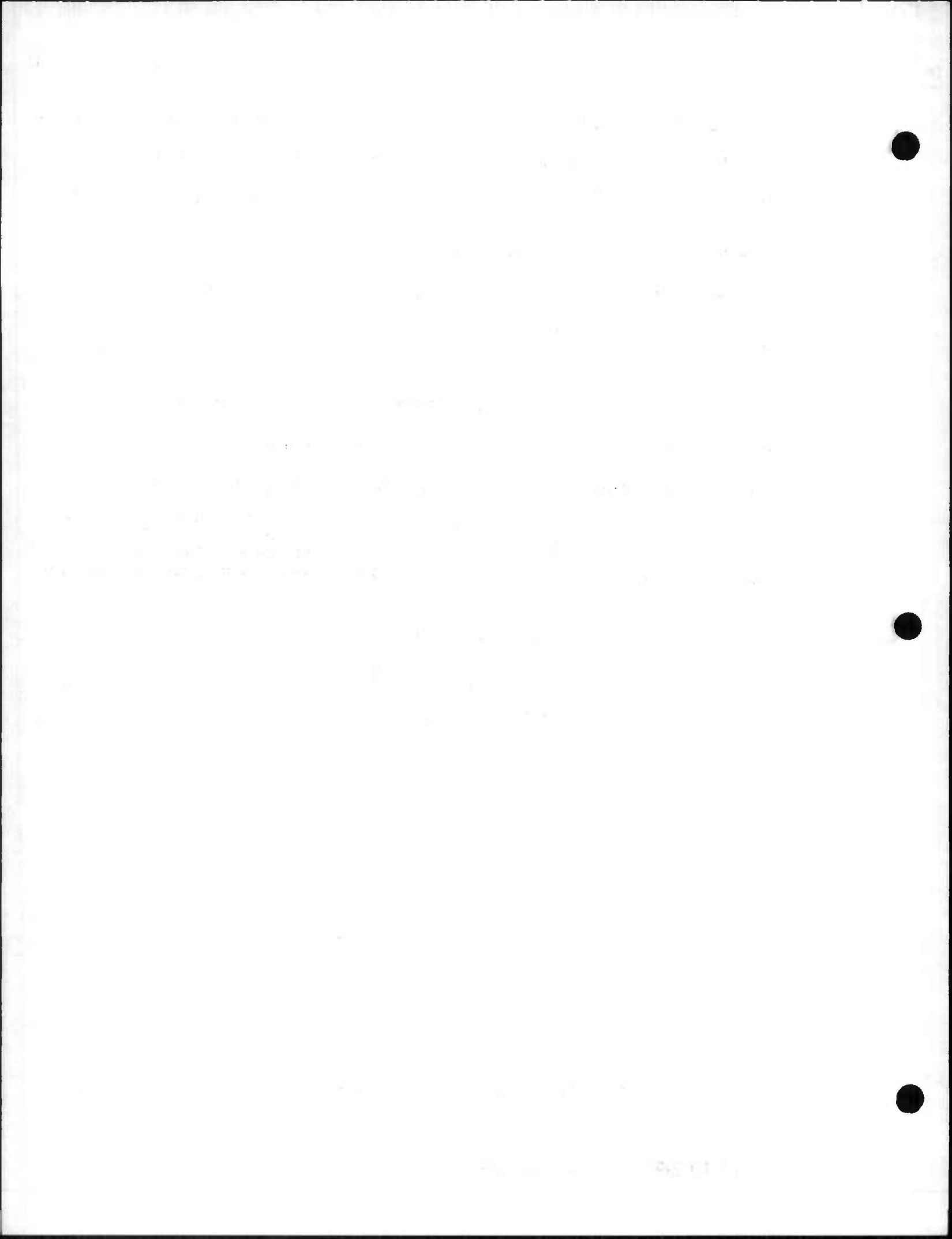
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04331

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT CHARLES DUCKETT | | | | 2. Date of Death
Month FEBRUARY Day 12 Year 1997 | | | | 3. Time of Death
11:55 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
FALLSTON GENERAL HOSPITAL | | | | 4b. City, Town, or Location of Death
FALLSTON | | | | 4c. County of Death
HARFORD | |
| Funeral
Director | 5. Social Security Number
217 18 6642 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 4 1924 | | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALOWIN | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
13710 BALOWIN MILL ROAD | | | | 10f. Zip Code
21013 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | 15. Decedent's Education (Specify only highest grade completed)
12 YRS. | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
SALES | | | | 16b. Kind of Business/Industry
RESTAURANT EQUIPMENT | | | | 17. Father's Name (First, Middle, Last)
ALBERT V. DUCKETT | |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)
E.M. ROSETTA HEISTERMAN | | | | 19a. Informant's Name/Relationship (Type, Print)
MARIE V. DUCKETT | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13710 BALOWIN MILL ROAD BALOWIN, MARYLAND 21013 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL CEMETERY | | | | 20c. Location - City or Town, State
BALTIMORE, MARYLAND | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
EVANS FUNERAL CHAPEL - BALAIR, P.A. 21000 3 NEWPORT DRIVE FOREST HILL, MARYLAND | | | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY ARREST
Due to (or as a consequence of):
b. SEPSIS
Due to (or as a consequence of):
c. SKIN INFECTION
Due to (or as a consequence of):
d. | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| | 29b. Signature and title of certifier
 | | | | 29c. License number
046667 | | | | 29d. Date signed (Month, Day, Year)
FEBRUARY 12, 1997 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. SYEDAH S. GILANI 4C NORTH AVE. SUITE 424 BALAIR, MARYLAND 21014 | | | | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | 32. Registrar's Signature
 | |
| | State Registrar | | | | DHMH 16 Rev 6/95 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04332

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
John Doyle | | 2. Date of Death
Month FEBRUARY Day 09 Year 1997 | | 3. Time of Death
07:49 AM | |
| 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| 5. Social Security Number
102-22-0279 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
67 Yrs. | |
| 8. Date of Birth (Month, Day, Year)
Nov. 26, 1929 | | 9. Birthplace (State or Foreign Country)
New York | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2613 Huntingdon Avenue | | 10f. Zip Code
21211 | |
| 10g. Citizen of What Country?
USA | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Korea | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Book Binder | | 16b. Kind of Business/Industry
Bookbinding | | 17. Father's Name (First, Middle, Last)
John Doyle | |
| 18. Mother's Name (First, Middle, Maiden Summa)
Christina Mc Carthy | | 19a. Informant's Name/Relationship (Type, Print)
Marguerite Montgomery Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
103 Sandy Beach Drive, Pasadena, Maryland 21122 | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD Veterans Cemetery | | 20c. Location - City or Town, State
2/13 Garrison Forest, MD | |
| 21. Signature of Funeral Service Licensee
Lynn B. Heness | | 22. Name and Address of Facility
Burgee-Henss Funeral Home 21211
3631 Falls Road, Baltimore, Maryland | | | |
| 23a. Permit under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ruptured Abdominal Aortic Aneurysm 5 hrs.
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE 15 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
PAUL R. LEWIS, M.D. | | 29c. License number
AT2438946-A50 | | 29d. Date signed (Month, Day, Year)
February 09, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL R. LEWIS, M.D. Union Memorial Hospital Baltimore | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04333

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LORETTA M EDWARDS | | | | | | 2. Date of Death
Month Day Year
FEBRUARY 13, 1997 | | 3. Time of Death
7:58 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA | | |
| Funeral
Director | 5. Social Security Number
214-24-9026 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs., last birthday)
66 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB 27, 1930 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | |
| 10e. Street and Number
760 DEACON HILL CT. | | 10f. Zip Code
21225 | | 10g. Citizen of What Country?
U.S.A | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: BLACK | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (9-12)
12th | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Nursing Aide | | 16b. Kind of Business/Industry
Hospital | | 17. Father's Name (First, Middle, Last)
RODGERS C. MOULDER | | 18. Mother's Name (First, Middle, Maiden Surname)
CLARA L. JOHNSON | |
| 19a. Informant's Name/Relationship (Type, Print)
JAVICE MADDEN | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
760 DEACON HILL CT. BALT, MD. 21225 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park | | 20c. Location - City or Town, State
Randallstown, Maryland | | 21. Signature of Funeral Service Licensee
[Signature] | |
| 22. Name and Address of Facility
Gary P. March Funeral Home 270 Fredhillton Pass Balto, MD 21229 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Cardiac arrhythmia
Myocardial Infarction
Coronary artery Disease
Hypertension | | Approximate Interval Between Onset and Death
2 hours
2 hours
years
years | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive heart failure.
EVA. | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Mohammad Saleem, MD | | 29c. License number
D40610 | | 29d. Date signed (Month, Day, Year)
February 13, 1997 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MOHAMMAD SALEEM, ST. AGNES HOSP. E.M. ROOM, | | 31. Date filed (Month, Day, Year)
FEB 14 1997 | |
| 32. Registrar's Signature
John Davidson-Randall | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

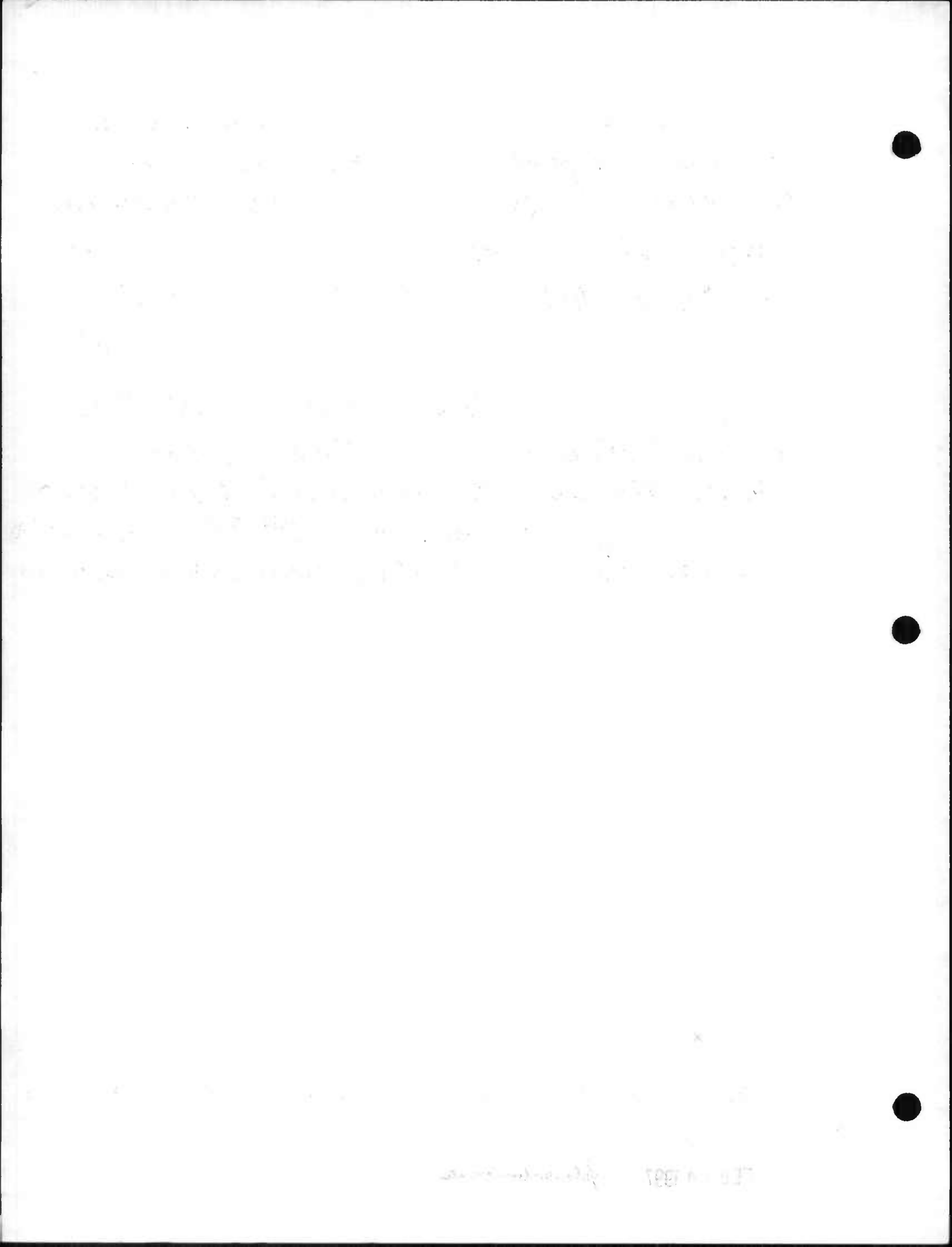
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital for Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and to the Funeral Director, this certificate should be detached for use as the burial-transit completely filed in the funeral director's office.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04334

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERALDINE

ECKERT

2. Date of Death

FEBRUARY 07 1997 9:00 P.M.

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

5. Social Security Number

219-01-1812

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 22, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

224 MAPLE AVE

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

HARRY PAUL HECK

18. Mother's Name (First, Middle, Maiden Surname)

IDA CATHERINE RULEY

19e. Informant's Name/Relationship (Type, Print)

Mary J. Eckert / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11924 Mays Chapel Rd. Timonium, Md 21093

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

FEB 10 1997

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS Chapel of Memories 8800 Harford Rd

Balto. Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

MONTHS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28982

29d. Date signed (Month, Day, Year)

Feb. 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERLANDO ROMERO M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 04335

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA L. ERICKSON

2. Date of Death
Month Day Year
Feb. 12, 1997

3. Time of Death
8:39 pm

4a. Facility Name (If not institution, give street and number)

41 Lawrence street

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

214-38-3350

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 23, 1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

41 Lawrence Street

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Louis Franklin Stevens Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Maria Moreland

19a. Informant's Name/Relationship (Type, Print)

George A. Erickson Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

171 Strawberry Lane, Centerville, MD 21617

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Cemetery

Date

2/15

20c. Location - City or Town, State

Annapolis, MD

21. Signature of Funeral Service Licensee

Robert J. Arnold

22. Name and Address of Facility

Hardesty Funeral Home, P.A.
12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary artery disease*

Due to (or as a consequence of):

b. *Diabetes*

Due to (or as a consequence of):

c. *HBP*

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Victor Plavner

29c. License number

028686

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR PLAVNER, M.D. 1509 RITCHIE HWY ARNOLD MD 21012

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04336

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|--|---|---|--------------------------------------|--|--|---|-----------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Helen G. Eaton | | | | 2. Date of Death
Month Feb. , Day 12 , Year 1997 | | 3. Time of Death
9:15 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
3939 Roland Avenue Apt. 307 | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
215-18-9770 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
90 Yrs. | | 8. Date of Birth (Month, Day, Year)
Nov. 26, 1906 | | |
| | 9. Birthplace (State or Foreign Country)
Virginia | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
3939 Roland Avenue Apt. 307 | | 10f. Zip Code
21211 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Seamstress | | 16b. Kind of Business/Industry
John Hopkins Hospital | | | | |
| | 17. Father's Name (First, Middle, Last)
John Gatewood | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Fristo | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Sarah Gill (Daughter) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4833 Roundhill Road Ellicott City, MD 21043 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadow Branch Cemetery | | 20c. Location - City or Town, State
2/15/97 Westminster, MD | | 20d. Date | | |
| | 21. Signature of Funeral Service Licensee
<i>Tracy H. Carpenter</i> | | | | 22. Name and Address of Facility
Burgee-Henss Funeral Home
3631 Falls Road Baltimore, Maryland 21211 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Suspected Underlying Malignancy of Gastrointestinal Tract.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, Advanced Age. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
R. Liberto, M.D. | | 29c. License number
D21464 | | 29d. Date signed (Month, Day, Year)
2/13/97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
3708 Bank St BALTO MD 21224 | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar
<i>Ja. Davidson-Randall</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04337

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY

2. Date of Death
Month Day Year

ELLIS FEBRUARY 11, 1997 8:37PM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

213-20-3808

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Nov. 27, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6440 Falkirk Road

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

Collage (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

City Manager

16b. Kind of Business/Industry

Cosmetics
Avon Company

17. Father's Name (First, Middle, Last)

Bernard John

Walkermeyer

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Regina Wurzbacher

19a. Informant's Name/Relationship (Type, Print)

William A. Ellis / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6440 Falkirk Road, Baltimore, Maryland 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Immanuel Lutheran Cemetery

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Guanta R Thomas

22. Name and Address of Facility

John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBROVASCULAR ACCIDENT

Approximate Interval Between Onset and Death

1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I:

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Boon P. Lim

29c. License number

D 37254

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Boon P. Lim

Baltimore, Maryland 21215-0620

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04338

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jean H. Gowran

2. Date of Death

February 8, 1997

3. Time of Death

12:58 p.m.

4a. Facility Name (If not institution, give street and number)

Howard County Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard Co.

Funeral
Director

5. Social Security Number

219-20-6144

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 20, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28 Carroll Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+ 2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Miller

19a. Informant's Name/Relationship (Type, Print)

William T. Gowran, Jr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28 Carroll Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery Feb. 13, 1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. mucous plug and atelectasis

Due to (or as a consequence of):

3 weeks

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D50785

29d. Date signed (Month, Day, Year)

Feb 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10805 Hickory Ridge Rd

Columbia MD

21044

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04339

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|---|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Concetta Cecilia Giacomazza</i> | | | | 2. Date of Death
Month <i>February</i> Day <i>11</i> , Year <i>1997</i> | | 3. Time of Death
<i>7:30 PM</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Lorien Frankford Nursing Center</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>N/A</i> | |
| Funeral
Director | 5. Social Security Number
<i>088-03-6930</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>85</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
<i>Feb. 27, 1911</i> | | 9. Birthplace (State or Foreign Country)
<i>Massachusetts</i> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<i>Maryland</i> | 10b. County
<i>Harford</i> | | 10c. City, Town or Location
<i>Fallston</i> | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
<i>1701 Parkvue Road</i> | | | 10f. Zip Code
<i>21047</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>8th grade</i> Collage (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Supervisor</i> | | 16b. Kind of Business/Industry
<i>Garment Industry</i> | | |
| | 17. Father's Name (First, Middle, Last)
<i>Joseph Cottone</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Vincenza Palmisano</i> | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Joseph DiGuardo (nephew)</i> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1701 Parkvue Road, Fallston, MD 21047</i> | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>Entombment</i> | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Dulaney Valley Mausoleum</i> | | 20c. Location - City or Town, State
<i>2/14/97 Timonium, Maryland</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
<i>Schimunek Funeral Homes, Inc.
9705 Belair Rd., Baltimore, Maryland 21236</i> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>Advanced Alzheimer's Dz.</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>atrial fibrillation</i>
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>mitral valve replacement</i>
<i>atrial fibrillation</i> | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>041291</i> | | 29d. Date signed (Month, Day, Year)
<i>2/13/97</i> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Immanuel Gutierrez, MD. 21 Crossroads Dr. #330 Owings Mills 21117</i> | | | | | | | | |
| 31. Data filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed in Part II, it is to be filed with the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04340

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Edward Harrison, Jr.

2. Date of Death
Month Day Year
02/12/973. Time of Death
9:10PM

4a. Facility Name (If not institution, give street and number)

Maryland Masonic Home

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

067-01-1536

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 28, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

300 International Circle

10f. Zip Code

21030

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Shipping

17. Father's Name (First, Middle, Last)

Charles Edward Harrison

18. Mother's Name (First, Middle, Maiden Surname)

Caroline Kempke

19a. Informant's Name/Relationship (Type, Print)

Maryland Masonic Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

300 International Circle Cockeysville, Maryland 21030

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

2-17-97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. gastrointestinal bleed

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

severe dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40208

29d. Date signed (Month, Day, Year)

2/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Irene Breiner MD 1205 York Rd Ste 320 Lutherville MD 21093

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04341

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM

HARPER

2. Date of Death

Month

Day

Year

FEBRUARY 11, 1997

3. Time of Death

10:10 PM

4a. Facility Name (If not institution, give street and number)

Mercy Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

None

Funeral
Director

5. Social Security Number

215/22/3381

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

8. Date of Birth

Apr. 11, 1928

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

None

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

714 N. Augusta Ave.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Site Coordinator

16b. Kind of Business/Industry

Gas & Electric Co.

17. Father's Name (First, Middle, Last)

James Harper

18. Mother's Name (First, Middle, Maiden Surname)

Pauline White

19a. Informant's Name/Relationship (Type, Print)

Hazel Harper - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

714 N. Augusta Ave. Baltimore, Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. National Cemetery

Date

2/18/97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Derrick C. Jones Funeral Home
4611 Park Heights Ave. Balto. Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one) STELLA MARIS AT MERCY

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40480

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO J. FERRAO, MD

5810 BELAIR RD
BALTO., MD 21206

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked "other than natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

11 11 11 11 11

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04342

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUCY

JANE

HICKS

2. Date of Death

February 13, 1997

Day Year

3. Time of Death

9:50 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

226-32-6581

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 26, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

911 S. Leadenhall St.

Apt.

512

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joe Turner

18. Mother's Name (First, Middle, Maiden Surname)

Della Dorsey

19a. Informant's Name/Relationship (Type, Print)

Mrs. Orlene M. Clark

(daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3432 W. Caton Ave. Floor Balto, Md. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

2/20/97

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of Lung with Brain Metastasis

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Cardiac Arrhythmias

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph L. Russ

29c. License number

89247

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Nsekenene Kolongo, M.D. 40 Maryland General Hospital

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



AL

Handwritten signature or mark.

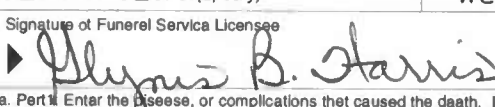
1874

Items: 23 part I, 27 per MEO G-744 2/26/97 reb
 Item: 16b, per F.H. G-744 2/14/97 reb

Certificate of Death

Reg. No.

97 04343

| | | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
THOMAS J. HICKS | | | 2. Date of Death
Month Day Year
FEBRUARY 10, 1997 | | | 3. Time of Death
11:16P.M. | | | |
| | 4e. Facility Name (If not Institution, give street and number)
4902 ALSTON DRIVE | | | 4b. City, Town, or Location of Death
BALTIMORE | | | 4c. County of Death
N/A | | | |
| Funeral
Director | 5. Social Security Number
214-58-9954 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
43 Yrs. | | 8. Date of Birth (Month, Day, Year)
6-12-1953 | | 9. Birthplace (State or Foreign Country)
Md | |
| | Usual Residence of Decedent | | | | | | | | | |
| 10a. State
Md | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10e. Street and Number
4902 Alston Drive | | | | 10f. Zip Code
21229 | | | | 10g. Citizen of What Country?
U S A | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Record Analysis Clerk | | | | 16b. Kind of Business/Industry
SOCIAL SECURITY ADMINISTRATION | | |
| 17. Father's Name (First, Middle, Last)
James Hicks, Sr | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Helen Murray | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
James Hicks, Sr Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
342 Bloom Street Apt 309 Baltimore, Md 21217 | | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Star Cem | | Date
21597 | | 20c. Location - City or Town, State
Catonsville, Md | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
March F/H West
4300 Wabash Avenue Baltimore, Md 21215 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

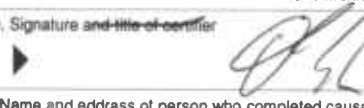
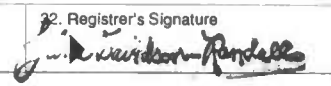
Immediate Cause (Final disease or condition resulting in death)
FATTY LIVER

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
FEBRUARY 11, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | | | | | | | |
| 32. Registrar's Signature
 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04344

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA V. Hartung

2. Date of Death

Feb 11, 1997

3. Time of Death

4:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Good Samaritan Nursing Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

215-06-6489

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 5, 1906

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1651 E. Belvedere, Apt-105

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7+H

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home maker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

John Bagdonas

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Sandusky

19a. Informant's Name/Relationship (Type, Print)

Clifford J. Hartung, Jr. / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

24 Ballyhawn Court, Timonium, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory, or other place)

Dulway Valley Mem. Gardens Feb. 13, 1997

Date

20c. Location - City or Town, State

Balt. MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.,
1501 E. Fort Ave. Balt. MD 2120023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

1 month

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D-17041

29d. Date signed (Month, Day, Year)

12 FEB 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark I Leaveny MD 7600 Osler Drive Ste 315 Baltimore MD 21204

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance in the theory of differential equations.

2. In the second part, we consider the case of a linear differential equation. It is shown that the problem is solvable in this case.

3. In the third part, we consider the case of a nonlinear differential equation. It is shown that the problem is solvable in this case.

4. In the fourth part, we consider the case of a system of differential equations. It is shown that the problem is solvable in this case.

5. In the fifth part, we consider the case of a partial differential equation. It is shown that the problem is solvable in this case.

6. In the sixth part, we consider the case of a boundary value problem. It is shown that the problem is solvable in this case.

7. In the seventh part, we consider the case of an initial value problem. It is shown that the problem is solvable in this case.

8. In the eighth part, we consider the case of a mixed boundary value problem. It is shown that the problem is solvable in this case.

9. In the ninth part, we consider the case of a problem with variable coefficients. It is shown that the problem is solvable in this case.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04345

Item 11 Per FH Film G744 2-26-97 rja

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John Huber | | 2. Date of Death
Month February Day 11 Year 1997 | | 3. Time of Death
9:15 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
Good Samaritan Hospital | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
212-10-2117 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Sept. 2, 1913 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore City |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
5401 Knell Avenue | | |
| | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| To Be Completed by Physician/Medical Examiner | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Foreman |
| | 16b. Kind of Business/Industry
Copper Refinery | | 17. Father's Name (First, Middle, Last)
John J. Huber | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Angela Warmuth |
| | 19. Informant's Name/Relationship (Type, Print)
Carolyn A. Price/daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15037 Laurel Oaks Lane, Laurel, Maryland 20707 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Location - City or Town, State
Beltsville, Maryland |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Guinita R Thomas | | 22. Name and Address of Facility
John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206 | | |
| | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Coronary Artery Disease
Due to (or as a consequence of):
Abdominal Aortic Aneurysm
Due to (or as a consequence of):
Colon Cancer
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death
Forty Years
Thirty Years
Twenty Years | | |
| | 23b. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23c. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Joyle Thompson M.D. | | |
| | 29c. License number
D47781 | | 29d. Date signed (Month, Day, Year)
February 11, 1997 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Joyle Thompson, M.D. 5601 Loch Raven Baltimore, Maryland 21239 | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
Julia Davidson-Randall | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "Natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04346

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|---|--|--|---|---|---|--|--|---|----|---------------|----------------------------------|---------------|----|-------------------------|----------------------------------|----------------|----|--|----------------------------------|---------------|----|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Clarence E. Hickman | | | | 2. Date of Death
Month February Day 1 , Year 1997 | | | | 3. Time of Death
2130 | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Harbor Hospital Center | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
Baltimore City | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
214-03-7021 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
78 Yrs. | | 8. Date of Birth (Month, Day, Year)
December 31, 1918 | | 9. Birthplace (State or Foreign Country)
Maryland | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
Baltimore City | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
1702 Patapsco Street | | | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
U.S.A. | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: WWII | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Sacred (0-12) 12th College (1-4 or 5+) 0 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Plumber | | | 16b. Kind of Business/Industry
Self Employed | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Warren Hickman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ethel (Unknown) | | | | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Emma Hickman (Wife) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1702 Patapsco Street Baltimore, Maryland 21230 | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery | | Date
2/12/97 | | 20c. Location - City or Town, State
Baltimore, Maryland | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee Kevin E. Ecker | | | | 22. Name and Address of Facility
McCully Funeral Home of Brooklyn
237 E. Patapsco Ave. Balto., MD. 21225 | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4"> Immediata Causa (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Sepsis</td> <td>Due to (or as a consequence of):</td> <td>1 week</td> </tr> <tr> <td>b.</td> <td>BRAIN METASTASIS</td> <td>Due to (or as a consequence of):</td> <td>10 DAYS</td> </tr> <tr> <td>c.</td> <td>ADENOCARCINOMA OF GASTROESOPHAGEAL JUNCTION</td> <td>Due to (or as a consequence of):</td> <td>1 YEAR</td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table> | | | | | | | | | | Immediata Causa (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Sepsis | Due to (or as a consequence of): | 1 week | b. | BRAIN METASTASIS | Due to (or as a consequence of): | 10 DAYS | c. | ADENOCARCINOMA OF GASTROESOPHAGEAL JUNCTION | Due to (or as a consequence of): | 1 YEAR | d. | | |
| Immediata Causa (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Sepsis | Due to (or as a consequence of): | 1 week | | | | | | | | | | | | | | | | | | | | | | |
| | b. | BRAIN METASTASIS | Due to (or as a consequence of): | 10 DAYS | | | | | | | | | | | | | | | | | | | | | | |
| | c. | ADENOCARCINOMA OF GASTROESOPHAGEAL JUNCTION | Due to (or as a consequence of): | 1 YEAR | | | | | | | | | | | | | | | | | | | | | | |
| | d. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
Anthony P. Dasaro | | | | 29c. License number
AS2441614-50 | | 29d. Date signed (Month, Day, Year)
February 1, 1997 | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
Anthony P. Dasaro 3001 South Hanover Street Baltimore Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
Richardson-Randall | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Office of the Secretary of the
Department of the Interior
Washington, D. C. 20540

AGREEMENT OF THE SECRETARY OF THE
DEPARTMENT OF THE INTERIOR
TO THE

AGREEMENT OF THE SECRETARY OF THE
DEPARTMENT OF THE INTERIOR
TO THE

AGREEMENT OF THE SECRETARY OF THE
DEPARTMENT OF THE INTERIOR
TO THE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04347

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Miles Jones

2. Date of Death
Month Day Year

February 12 1997

3. Time of Death

1:20 pm

4e. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-80-6974

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

6-24-61

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4726 Parkside Drive

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1981 to 1983

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4or 5+)
NA16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

William H. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Helen W. Wallace

19a. Informant's Name/Relationship (Type, Print)

Carolyn Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4726 Parkside Drive Balto, Md 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kings Memorial Park

Date

2/17/97

20c. Location - City or Town, State

Randallstown, MD

21. Signature of Funeral Service Licensee

Sharon Stokes

22. Name and Address of Facility

March Funeral Home West
4300 Wabash Avenue, Baltimore, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumococcal Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intravenous Drug Abuse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Craig Gold DO

29c. License number

AS 2402321-CG-9919

29d. Date signed (Month, Day, Year)

February 12 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Craig Gold DO Sinai Hospital 2401 West Belvedere Avenue Baltimore, Maryland 21215

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

John Jackson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death in the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 28a shows any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in Part II, the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04348

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alice P. Jones

2. Date of Death

February 10, 1997

3. Time of Death

4:00 p.m.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

219-18-8533

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 6, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8486 Bedford Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

LeRoy M. Bell

18. Mother's Name (First, Middle, Maiden Summa)

Anna Mae Allen

19a. Informant's Name/Relationship (Type, Print)

Darnell P. Fried Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4002 Alberta Ave. Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery Feb. 13, 1997

Data

20c. Location - City or Town, State

Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home

3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Abdominal aortic aneurysm
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic heart disease
Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

A. Gudwin, MD 7300 Ritchie Hwy, Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04349

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cecilia T. KRASTEL

2. Date of Death

Month
FEBDay
9Year
1997

3. Time of Death

1:51 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Greater BALTIMORE MEDICAL Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-03-6267

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT 16, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

ESSEX

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

140 HOLLY CIRCLE

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

JACOB SPAHN

18. Mother's Name (First, Middle, Maiden Surname)

Catherine UZEBER

19a. Informant's Name/Relationship (Type, Print)

Robert KRASTEL / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

140 Holly Circle Baltimore, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. JOSEPH Cemetery

Date

Feb 12 1997

20c. Location - City or Town, State

FULLERTON, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS Chapel & Memories 8800 Harford Rd.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BACTERIAL PNEUMONIA

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WK

2 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47707

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RITA PABLA MD 6565 N. Charles St STE 203 BALTIMORE, MD. 21204

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04350

Item: 19a, per Anatomy Board G-744 2/14/97^{reb} Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|-------------------|---|--|---|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Betty E. Kennedy | | | | 2. Date of Death
Month Day Year
January 25 1997 | | 3. Time of Death
12:50 am | | | | |
| | 4a. Facility Name (If not institution, give street and number)
2405 Allendale Road | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | | | | |
| Funeral
Director | 5. Social Security Number
216-16-6696 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
74 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 15, 1922 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| 10a. State
Maryland | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 10e. Street and Number
2405 Allendale Road | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown
College (1-4 or 5+) unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | 16b. Kind of Business/Industry
Homemaker | | | | |
| 17. Father's Name (First, Middle, Last)
George O'Rourke | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Carrie Euler | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
HARMON
Ronald Buchanan/Son | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
410 S. Buchanan Blvd., Durham, North Carolina 27701 | | | | | | |
| 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place) | | | Date | | 20c. Location - City or Town, State | | | |
| 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | | | | 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201 | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | Approximate Interval Between Onset and Death | |
| Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | | MINUTES | |
| Due to (or as a consequence of):
SEVERE HYPOXEMIA | | | | | | | | | | | |
| Due to (or as a consequence of):
ACUTE BRONCHOPNEUMONIA | | | | | | | | | | ONE DAY | |
| Due to (or as a consequence of):
VIRAL UPPER RESPIRATORY INFECTION | | | | | | | | | | 2-3 DAYS | |
| Due to (or as a consequence of): | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CORONARY ARTERY INSUFFICIENCY | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | 26a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
end manner stated. | | | 29b. Signature and title of certifier
Joseph D. Notarangelo M.D. | | | | | | | 29c. License number
D07316 | |
| 29d. Date signed (Month, Day, Year)
FEB-4-1997 | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JOSEPH D. NOTARANGELO M.D. 301 ST. PAUL PLACE BALTIMORE MD 21202 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | 32. Registrar's Signature
John Davidson-Randall | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04351

Item 8 PerFH Film G744 2-28-97 rja

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Wayne Keats

2. Date of Death

February 13, 1997

3. Time of Death

3:52 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

5. Social Security Number

216-32-3972

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 37

April 3, 1939

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

233 Spring Gap South

10f. Zip Code

20724

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Flooring

17. Father's Name (First, Middle, Last)

Clayton O. Keats

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Jane Powell

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Keats/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

233 Spring Gap South, Laurel, Maryland 20724

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

2/17/97

20c. Location - City or Town, State

Brooklyn Park, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, INC.

7601 Sandy Spring Road Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Acute Myocardial Infarction
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary Artery Disease/Hypertension
Due to (or as a consequence of):c. Hypercholesterolemia Smoking
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D13685

29d. Date signed (Month, Day, Year)

2-13-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRZA HUSSEIN ALI BAIG MD

7350 VanDusen Road, Laurel, MD 20707

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in its entirety, it must be delivered to the funeral director, page 2 should be detached for use as the burial-transit certificate.

20

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04352

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Neil Kurlander

2. Date of Death

February 4 1997

Day

Year

3. Time of Death

1445

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

127-28-0814

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 24, 1936

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3314 MIDFIELD ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ATTORNEY

16b. Kind of Business/Industry

LAW

17. Father's Name (First, Middle, Last)

HERMAN

KURLANDER

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES

LEBOW

19a. Informant's Name/Relationship (Type, Print)

MRS. ELAINE KURLANDER (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3314 MIDFIELD ROAD BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW

Date

2-7-1997- REISTERSTOWN, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

Craig Levinson

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Endocarditis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis
Due to (or as a consequence of):c. Intracerebral Hemorrhage
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Mitral Valve Prolapse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - (At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Craig Gold

29c. License number

AS 2402321-CG-9919

29d. Date signed (Month, Day, Year)

February 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinai Hospital 2401 West Belvedere Avenue Baltimore, Maryland 21215

State
Registrar

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Julian Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04353

Item 5 per FH Film G744 2-28-97 rja

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ROBERT J. KELLER | | | | 2. Date of Death
Month FEB Day 11 Year 1997 | | 3. Time of Death
12:15pm | |
| | 4a. Facility Name (If not institution, give street and number)
3415 Merrimac Road | | | | 4b. City, Town, or Location of Death
Davidsonville | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
216-32-0254 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
70 yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
Jan 29 1927 | 9. Birthplace (State or Foreign Country)
Michigan |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Md | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Davidsonville | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
3415 Merrimac Road | | | | 10f. Zip Code
21035 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1944-50 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Contractor | | 16b. Kind of Business/Industry
Painting | | |
| 17. Father's Name (First, Middle, Last)
Ambrose Raymond Keller | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Fauniel Gant | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Edith May Keller | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3415 Merrimac Rd., Davidsonville, Md 21035 | | | | |
| 20e. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Cemetery | | Date
Feb 14 1997 | | 20c. Location - City or Town, State
Davidsonville Md | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Hardesty Funeral Home PA
12 Ridgely Ave., Annapolis, Md 21401 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Metastatic Small Cell Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
3 months
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D16354 | | 29d. Date signed (Month, Day, Year)
2-12-97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Enser W. Cole III 900 Bestgate Rd Annapolis, MD 21401 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04354

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Delores Beall Lanham

2. Date of Death

Feb. 11, 1997

3. Time of Death

11:50am

4a. Facility Name (If not institution, give street and number)

Crofton Conv. Nursing Home

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

220-26-7125

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 30, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1875 Poplar Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Leslie Beall

18. Mother's Name (First, Middle, Maiden Surname)

Doris Renellda Holland

19a. Informant's Name/Relationship (Type, Print)

Joann Marie Hendricks

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1875 Poplar Road, Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lakemont Cemetery

Date

2/14

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Meningitis*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D29571

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1655 CROFTON BLVD, Suite 101, CROFTON MD. 21114

State
Registrar

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04355

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|--|--|--|-----------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Mary Elizabeth Langan | | | | 2. Date of Death
Month Day Year
February 13 1997 | | | | 3. Time of Death
6:10 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Home Health | | | | 4b. City, Town, or Location of Death
Towson | | | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
218-18-0634 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
11/12/07 | | 9. Birthplace (State or Foreign Country)
VIRGINIA | |
| | Usual Residence of Decedent | | | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
PARKVILLE | |
| To Be Completed by Funeral Director | 10e. State | | 10f. Zip Code | | 10g. Citizen of What Country? | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
1926 EDGEWOOD ROAD | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
USA | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
1 YEAR | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PROOFREADER | | 16b. Kind of Business/Industry
INSURANCE CO. | | | | | |
| | 17. Father's Name (First, Middle, Last)
B. May CORNELIUS | | | | 18. Mother's Name (First, Middle, Maiden Surname)
May Douty | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
JOHN LANGAN, JR. SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1926 EDGEWOOD ROAD PARKVILLE, MD 21234 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MORELAND MEM. PARK | | Date
2/17/97 | | 20c. Location - City or Town, State
HILLENDALE, MD | | | |
| | 21. Signature of Funeral Service Licensee
<i>Christina A. Kopczynski</i> | | | | 22. Name and Address of Facility
JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.
TOWSON, MD 21286 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Heart Disease
Due to (or as a consequence of):
<i>Myocardial infarction</i>
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
<i>months</i> | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Chronic lung disease</i> | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA | | 26. Place of Death (Check only one)
Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>John Davidson</i> | | 29c. License number
J15504 | | 29d. Date signed (Month, Day, Year)
2-13-97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Towson, MD 21204 | | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
<i>John Davidson</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04356

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth

LEDWELL

2. Date of Death
Month Day Year

February 10, 1997

3. Time of Death
5:30 P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-16-5867

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

March 26, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

510 Wampler Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

David J. Manley

18. Mother's Name (First, Middle, Maiden Surname)

Mary Combs

19a. Informant's Name/Relationship (Type, Print)

Dale L. Ledwell /husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

510 Wampler Road Baltimore Md. 21220

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gardens of Faith Cemetery 2/14/97 Rossville Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 Mace Ave. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Milner

29c. License number

D18598

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Milner 406 Eastern Ave. Baltimore Md. 21221

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

J. Davidson

State
Registrar

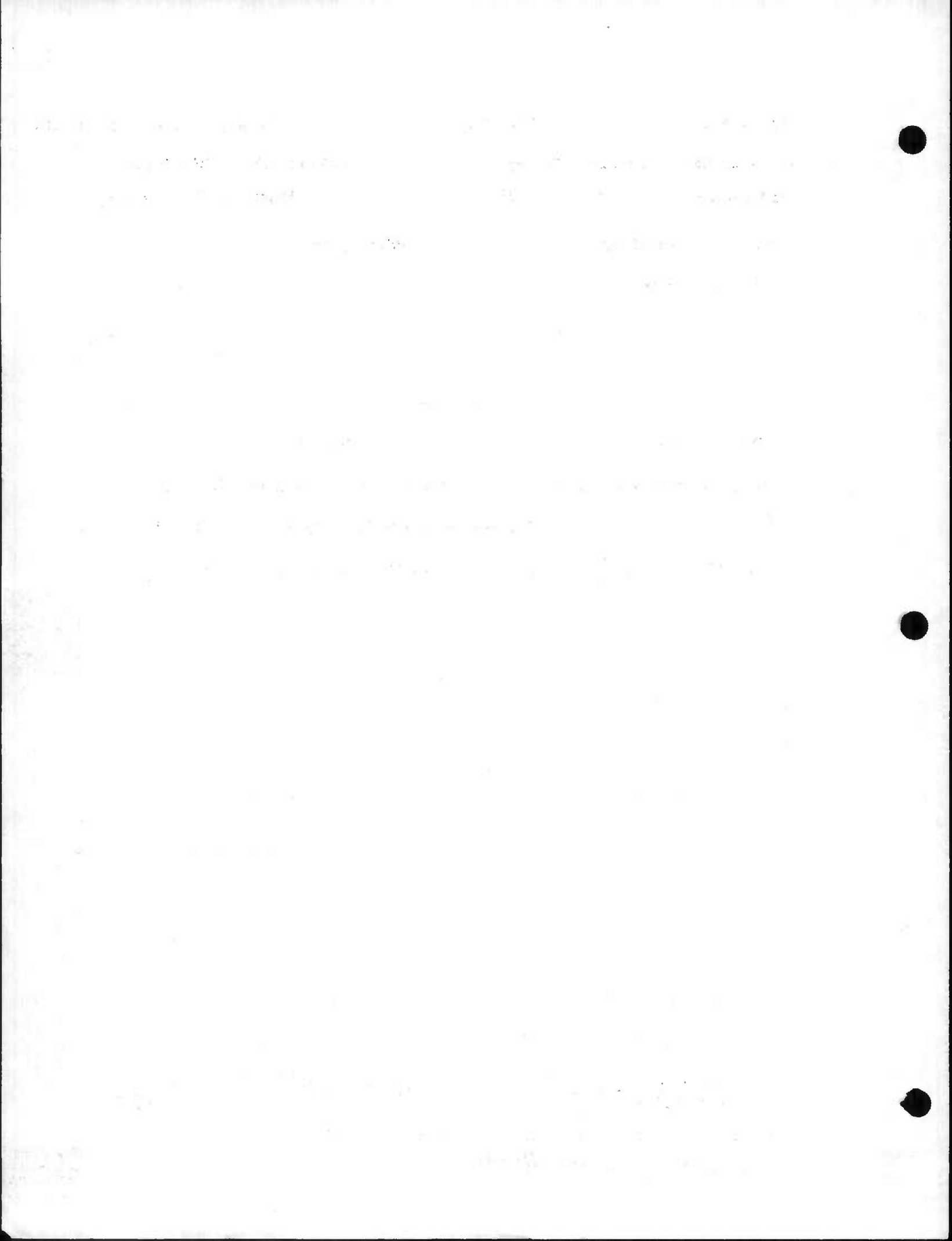
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completed by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04357

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MINNIE MOORE | | | | 2. Date of Death
Month February Day 10th Year 1997 | | 3. Time of Death
3:45 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
CHURCH HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
CITY | |
| Funeral
Director | 5. Social Security Number
214 40 7187 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
98 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
April 18, 1898 | 9. Birthplace (State or Foreign Country)
Virginia |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
1601 E. Belvedere Ave. | | | | 10f. Zip Code
21239 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (13-16 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Custodian | | 16b. Kind of Business/Industry
School System | | |
| 17. Father's Name (First, Middle, Last)
William Brown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Brown | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Yvette Laidlow (niece) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
409 N. Wolfe St. Balto, Md. 21231 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus | | Date
2/13/97 | | 20c. Location - City or Town, State
Balto. Md. | |
| 21. Signature of Funeral Service Licensee
Joseph L. Russ | | | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
a. Rectal Bleeding, HYPOTENSION
Due to (or as a consequence of):
b. Rectal Cancer
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
Sunil Ahuja M.D. | | 29c. License number
D 28762 | | 29d. Date signed (Month, Day, Year)
2/10/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
SUNIL AHUJA M.D. CHURCH HOSPITAL, E.R., BALTIMORE MD 21231 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
John Davidson | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04358

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Violet Mahoney

2. Date of Death

Month Day Year
Feb. 6, 1997

3. Time of Death

10:40 p.m.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4033 Brummel Road

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

5. Social Security Number

213-22-0704

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 27, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland10b. County
Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4033 Brummel Road

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
9Collage (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laundry Worker

16b. Kind of Business/Industry

Fort Meade

17. Father's Name (First, Middle, Last)

John Henry Watts

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ethel Johnson

19a. Informant's Name/Relationship (Type, Print)

Marty Mahoney Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 11th Ave. N.W. Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion Church Cemetery Feb. 12, 1997 Pasadena, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home

3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Extensive CA urinary bladder

Due to (or as a consequence of):

12/30/96

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Metastatic disease to rt. acetabulum

Due to (or as a consequence of):

" "

c. severe anemia

Due to (or as a consequence of):

" "

d. cachexia

" "

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Right Kidney obstruction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury et
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08801

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICK P. MOUTSOS 295 Aqueduct RD GB, MD 21061

31. Date filed (Month, Day, Year)

FEB 14 1997

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04359

Items: 23 part I, 27 per MEO G-745 3/10/97 ^{Feb} Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIAM Donnell MILLER | | | | 2. Date of Death
Month Day Year
FEB. 09, 1997 | | 3. Time of Death
3:20 PM. | |
| | 4a. Facility Name (If not Institution, give street and number)
16 BIRCH AVE. | | | | 4b. City, Town, or Location of Death
GLEN BURNIE | | 4c. County of Death
Anne Arundel | |
| Funeral
Director | 5. Social Security Number
214-54-1099 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
49 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 17 1947 | |
| | 9. Birthplace (State or Foreign Country)
Baltimore, Md. | | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent
10a. State Md. 10b. County Anne Arundel Co. 10c. City, Town or Location Glen Burnie | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
16 Birch Ave. | | | | 10f. Zip Code
21061 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Vietnam | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerk | | 16b. Kind of Business/Industry
CSX Chessie Sytems | | | |
| | 17. Father's Name (First, Middle, Last)
William Henry Miller, Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Kathryn Louise Good | | | |
| | 19e. Informant's Name/Relationship (Type, Print)
William H. Miller/Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Birch Ave. Glen Burnie, Md. 21061 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. | | Data
FEB. 10 1997 | | 20c. Location - City or Town, State
Catonsville, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
McCully Funeral Home of Brooklyn
237 E. Patapsco Ave. Baltimore, Md. 21225 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

AORTIC VALVE STENOSIS WITH CARDIOMEGALY | | | | | | | |
| | <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </div> <div style="width: 60%;"> a. Due to (or as a consequence of):

 b. Due to (or as a consequence of):

 c. Due to (or as a consequence of):

 d. Due to (or as a consequence of): </div> </div> | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24e. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
FEB. 10, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. Reynolds P. Konow 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24e-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04360

ITEM#3 per PHYS FLM#G744 2-14-97 J.A. Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Mai

2. Date of Death

Jan. 28, 1997

3. Time of Death

UNKNOWN - M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

10208 Bevans Lane

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

216-09-1657

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 29, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10208 Bevans Lane

10f. Zip Code

21220

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank Nemec

18. Mother's Name (First, Middle, Maiden Surname)

Berta Dermec

19e. Informant's Name/Relationship (Type, Print)

Jeffrey Mai

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10208 Bevans Lane, Balto., Md. 21220

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory 130 -97 Beltsville, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley-Ashton Funeral Home, Inc.

2134 Willow Spring Rd., Balto., Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Coronary Artery Disease

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Diabetes Mellitus

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ray H. Myint MD

29c. License number

D 47990

29d. Date signed (Month, Day, Year)

1/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAY H. MYINT, EAST POINT MEDICAL CENTER 1012 Northpoint Rd 21224

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

G-744 2-27-97 eoh

State of Maryland / Department of Health and Mental Hygiene

97 04361

ITEM:10acefq,11,12,13,17,18,19ab.PERINFORMANT Certificate of Death

Reg. No.

| | | | | | |
|---|--|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Fredrick Moore | | 2. Date of Death
Month 2 Day 8 Year 97 | | 3. Time of Death
943 AM |
| | 4a. Facility Name (If not institution, give street and number)
Ravenwood Nursing and Rehab Center | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore city |
| Funeral
Director | 5. Social Security Number
218-86-8508 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
33 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
12-28-63 | | 9. Birthplace (State or Foreign Country)
unknown | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1808 ST PAUL ST
501 W. Franklin Street | | 10f. Zip Code
21201 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
unknown
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
unknown
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
unknown
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown
College (1-4 or 5+) unknown | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
unknown | | 16b. Kind of Business/Industry
unknown | | |
| | 17. Father's Name (First, Middle, Last)
unknown ALLEN THEODORE MOORE | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown DEROSSETTA HURT | | |
| | 19a. Informant's Name/Relationship (Type, Print)
unknown KEVIN L MOORE | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
unknown 3313 WINTERBOURNE RD | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in-state | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201 | | 20c. Location - City or Town, State |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
e. Severe Wasting Syndrome
Due to (or as a consequence of):
b. Acquired Immunodeficiency Syndrome
Due to (or as a consequence of):
c. _____
Due to (or as a consequence of):
d. _____ | | | | 1 Year
more than 5 Years |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Drug dependency; Anemia; Dementia | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
None | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
Robert Kent, MD. | | 29c. License number
D06966 | | 29d. Date signed (Month, Day, Year)
Feb. 8, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Robert Kent, MD 1001 N. Cathedral ST. Baltimore, MD 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
[Signature] | | | |

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be clearly documented, including the date, amount, and purpose of the transaction. This ensures transparency and allows for easy verification of the data.

2. The second part of the document outlines the procedures for handling discrepancies. It states that any difference between the recorded amounts and the actual amounts must be investigated immediately. The responsible parties should identify the source of the error and take steps to correct it, ensuring that the records remain accurate and reliable.

3. The third part of the document describes the process for reconciling accounts. It requires that all accounts be reconciled at the end of each month. This involves comparing the recorded transactions with the actual bank statements and ensuring that they match. Any discrepancies should be noted and resolved promptly.

4. The fourth part of the document discusses the importance of regular audits. It states that audits should be conducted at least once a year to ensure that all records are accurate and that all transactions are properly documented. Audits also help to identify any potential areas of improvement and ensure that the system is working effectively.

5. The fifth part of the document outlines the responsibilities of the staff involved in the accounting process. It states that all staff members must be trained in the proper use of the accounting system and must follow the established procedures. It also emphasizes the importance of maintaining confidentiality and ensuring that all information is kept secure.

6. The sixth part of the document discusses the importance of maintaining up-to-date records. It states that all records should be kept for a minimum of five years. This ensures that there is a complete history of all transactions and allows for easy access to the data when needed. It also emphasizes the importance of backing up the records regularly to prevent data loss.

7. The seventh part of the document outlines the process for closing the books at the end of the year. It states that all transactions should be recorded and reconciled before the books are closed. This ensures that the financial statements are accurate and that all transactions are properly accounted for. It also emphasizes the importance of reviewing the records and identifying any areas of improvement for the following year.

8. The eighth part of the document discusses the importance of maintaining accurate records of all assets and liabilities. It states that all assets should be properly valued and recorded, and all liabilities should be accurately tracked. This ensures that the financial statements provide a true and accurate picture of the organization's financial position.

9. The ninth part of the document outlines the process for preparing the financial statements. It states that the financial statements should be prepared at the end of each year and should include the balance sheet, income statement, and cash flow statement. It also emphasizes the importance of reviewing the statements and ensuring that they are accurate and reliable.

10. The tenth part of the document discusses the importance of maintaining accurate records of all taxes. It states that all taxes should be properly calculated and recorded, and that all tax returns should be filed on time. This ensures that the organization is in compliance with all applicable tax laws and avoids any potential penalties or fines.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04362

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALVERTA E. NELSON

2. Date of Death

Month Day Year
FEBRUARY 11, 1997

3. Time of Death

1:25 pm

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

214-14-7055

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 11, 1905

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4800 Seton Drive

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (10-12)
11th gradeCollege (1-4 or 5+)
NA16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Maid

16b. Kind of Business/Industry

Horton Motor
Lounge

17. Father's Name (First, Middle, Last)

Elijah Scott

18. Mother's Name (First, Middle, Maiden Summa)

Harriett Scott

19a. Informant's Name/Relationship (Type, Print)

Randolph Nelson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4219 Flowerton Road Balto, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Arbutus Mem Park

Date

2-14-97

20c. Location - City or Town, State

Arbutus, MD

21. Signature of Funeral Service Licensee

Gabrielle Cook

22. Name and Address of Facility

March F. H. West
4300 Wabash Avenue Balto, MD 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. SEPSIS
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

2 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. PNEUMONIA
Due to (or as a consequence of):

7 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ABDOMINAL AORTIC ANEURYSM, DEMENTIA,

CORONARY ARTERY DISEASE, DIABETES

MELLITUS TYPE II

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Eric J. Carr, MD

29c. License number

AS-2402321-EC-9005

29d. Date signed (Month, Day, Year)

2/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERIC J. CARR, MD

SINAI HOSPITAL OF BALTIMORE

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Jung Davidson

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after completion of the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04363

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Nadine Omansky | | | | 2. Date of Death
Month Day Year
February 14 1997 | | 3. Time of Death
7:00 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
219 10 2781 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
89 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 29, 1908 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
n/a | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
4216 Kenshaw Ave. | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own home | | | |
| | 17. Father's Name (First, Middle, Last)
William Fox | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude Gannon | | 19a. Informant's Name/Relationship (Type, Print)
Margaret Pfeffer / friend | | | |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4218 Kenshaw Ave., Baltimore, MD 21215 | | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | 20c. Location - City or Town, State
Baltimore MD | |
| | 21. Signature of Funeral Service Licensee
Stephen D. Lohrmann | | 22. Name and Address of Facility
CAFA Stephen D. Lohrmann PA.
8717 Green Pastures Dr., Baltimore, MD 21286 | | | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Aspiration pneumonia
Due to (or as a consequence of):
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | Approximate Interval Between Onset and Death | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, peptic ulcer disease, epidural hematoma
deafness from childhood meningitis | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
6K-9062 | | 29d. Date signed (Month, Day, Year)
February 14, 1997 | |
| | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
2401 W Belvedere Avenue Baltimore, MD 21215 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

JA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item8 2-19-97 FilmG744 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

97 04364

Certificate of Death

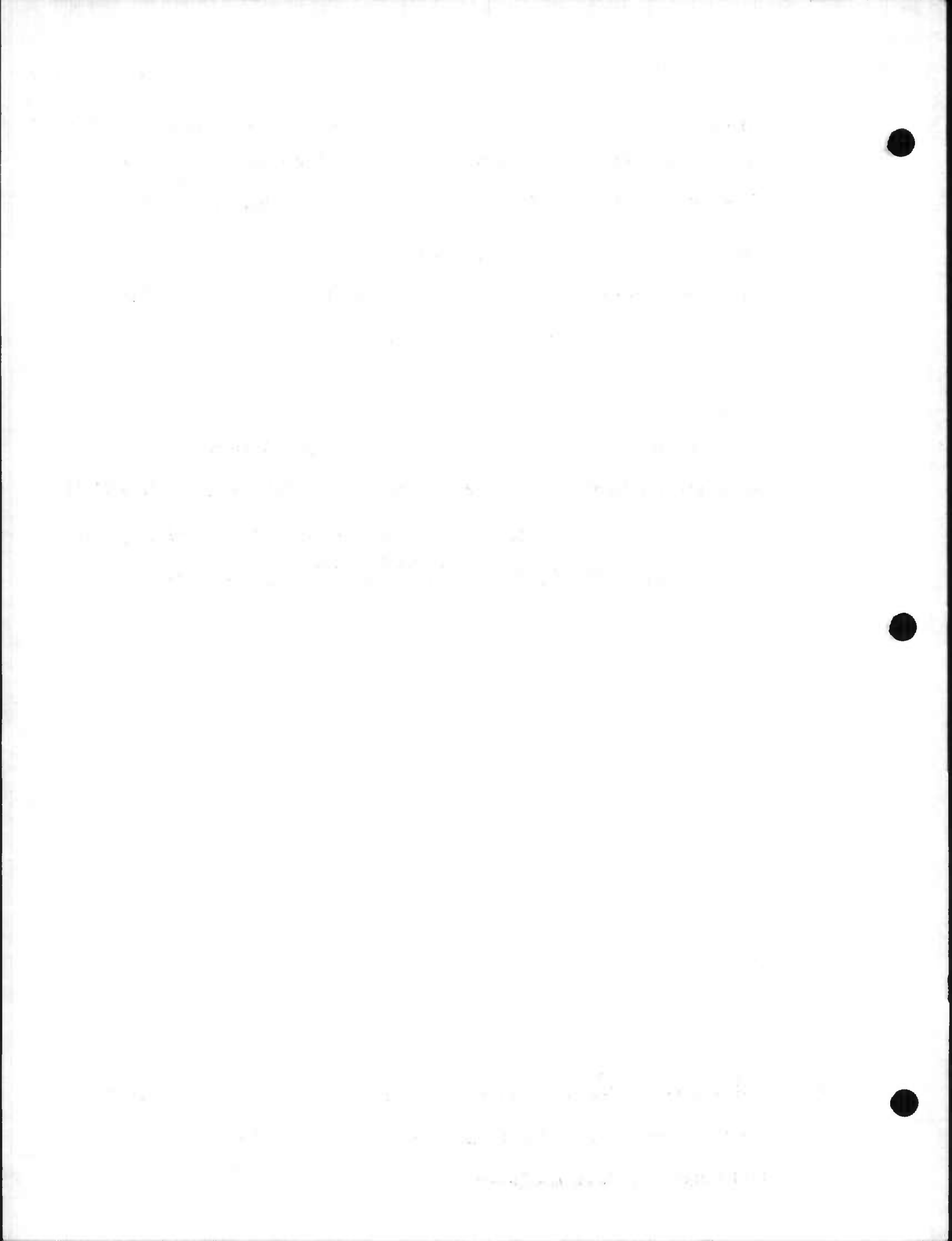
Reg. No.

| | | | | | | | | |
|--|---|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>James Orlandi</u> | | | | 2. Date of Death
Month <u>2</u> Day <u>6</u> Year <u>97</u> | | 3. Time of Death
<u>830 pm</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Johns Hopkins Bayview Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>N/A</u> | |
| Funeral
Director | 5. Social Security Number
<u>217-68-0010</u> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>41</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>Aug. 4, 1955</u> | |
| | 10a. State
<u>Maryland</u> | | 10b. County
<u>N/A</u> | | 10c. City, Town or Location
<u>Baltimore</u> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
<u>3632 Elmora Avenue</u> | | | | 10f. Zip Code
<u>21213</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>White</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
<u>Elementary/Secondary (0-12)</u> | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Painter</u> | | 16b. Kind of Business/Industry
<u>Unknown</u> | |
| | 17. Father's Name (First, Middle, Last)
<u>James G. Orlandi</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Marie Youngbar</u> | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
<u>Marie Orlandi (Mother)</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>3632 Elmora Avenue, Baltimore, Maryland 21213</u> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Gardens of Faith Cemetery</u> | | 20c. Location - City or Town, State
<u>2-10 Baltimore, Maryland</u> | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | | | 22. Name and Address of Facility
<u>Schimunek Funeral Home</u>
<u>3331 Brehms Lane, Baltimore, Maryland 21213</u> | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <u>Cirrhosis</u>
Dua to (or as a consequence of):
b. <u>esophageal varices</u>
Dua to (or as a consequence of):
c. <u>Hepatitis C</u>
Dua to (or as a consequence of):
d. <u>EtOH abuse</u> | | | | Approximate Interval Between Onset and Death
<u>years</u>
<u>years</u>
<u>years</u>
<u>years</u> | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | | | | | 23b. Did tobacco use contribute to the causa of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| State
Registrar | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<u>[Signature] M.D.</u> | | 29c. License number
<u>96712</u> | |
| | 29d. Date signed (Month, Day, Year)
<u>2-6-97</u> | | | | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
<u>Hyon Seo 4940 Eastman Ave Baltimore, MD 21224</u> | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
<u>FEB 14 1997</u> | | | | 32. Registrar's Signature
<u>[Signature]</u> | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04365

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA RUTH BRADLEY POTOLEC

2. Date of Death
Month Day Year

February 11, 1997

3. Time of Death

6:10 PM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN NURSING CENTER

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-01-7879

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Nov. 15, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1601 E. Belvedere Avenue

10f. Zip Code

21139

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Insurance Brokerage

17. Father's Name (First, Middle, Last)

Daniel Joseph Bradley, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Cecilia Nixon

19a. Informant's Name/Relationship (Type, Print)

Mary C. Sullivan (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 Dexter Road, Wellesey, MA 02181

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

New Cathedral Cemetery

Date

2/17/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recurrent Urinary Tract Infarctions

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Nancy Friedley, M.D.

29c. License number

D46504

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy Friedley, M.D., 5601 Loch Raven Blvd, G-3, Baltimore, Maryland 21239

31. Date filed (Month, Day, Year)

FEB 14 1997

Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 19a 2-14-97 Film G744 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

97 04366

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|--|---|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Elena Palmer</i> | | | | 2. Date of Death
Month Day Year
<i>February 12, 1997</i> | | 3. Time of Death
<i>5:45 pm</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Northwest Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>230-30-7008</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>86</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>6-25-10</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>Cooksville, MD</i> | | 10a. State
<i>MD</i> | | 10b. County
<i>NA</i> | | 10c. City, Town or Location
<i>Baltimore</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
<i>3927 Bareva Rd.</i> | | 10f. Zip Code
<i>21215</i> | |
| | 10g. Citizen of What Country?
<i>USA</i> | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i>NA</i> | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Child care</i> | | | | 16b. Kind of Business/Industry
<i>Domestic</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Herbert Prettyman</i> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Cora Smith</i> | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name Relationship (Type, Print)
<i>Louis Palmer</i> (Friend) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3422 Yataruba Dr. Baltimore, MD 21207</i> | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Cooksville cemetery</i> | | | |
| | 20c. Location - City or Town, State
<i>2-17-97 Cooksville, MD</i> | | | | 21. Signature of Funeral Service Licensee
<i>Albert P. Wylie</i> | | | |
| | 22. Name and Address of Facility
<i>Albert P. Wylie F.H. PA
638 N. 61st St. Baltimore, MD 21217</i> | | | | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final disease or condition resulting in death)

a. <i>Sepsis with multiple organ failure</i>
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020 | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
<i>M</i> | | | |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how injury occurred | | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
<i>Allice Smith</i> | | | |
| 29c. License number
<i>H43974</i> | | | | 29d. Date signed (Month, Day, Year)
<i>February 12, 1997</i> | | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Heidi Allice Smith Northwest Hospital Randallstown, MD</i> | | | | | | | |
| | 31. Date filed (Month, Day, Year)
<i>FEB 14 1997</i> | | | | 32. Registrar's Signature
<i>John Davidson-Randall</i> | | | |

97 04367

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
SIERRA PLAYER | | | | 2. DATE OF DEATH
MONTH FEB DAY 13 YEAR 97 | | 3. TIME OF DEATH
2 51 P M | | | |
| 4. SOCIAL SECURITY NUMBER
215-11-1003 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)
11 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7. DATE OF BIRTH
(Month, Day, Year)
1-18-86 | | 8. BIRTHPLACE (State or Foreign Country)
MD. USA | |
| 9a. FACILITY NAME (If not institution, give street and number)
Mount Washington Pediatric Hosp | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
BALTIMORE, MD | | | 9c. COUNTY OF DEATH
BALT-CITY | | |
| 10a. STATE
MD | | 10b. COUNTY
n/a | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
1621 Veney Ct. | | | | 10f. ZIP CODE
21237 | | 10g. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) n/a
College (1-4 or 5+) n/a | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
n/a | | | 16b. KIND OF BUSINESS/INDUSTRY
n/a | | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Gary Player | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Brenda Edwards | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Jeanette Darden/grandmother | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
431 N. Lakewood Ave. Balto., MD 21224 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 2/18 | | OATE
2/18 | | 20c. LOCATION — City or Town, State
Baltimore, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
James A. Morton | | | | 22. NAME AND ADDRESS OF FACILITY
James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 21217 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

a. ANOXIC BRAIN INJURY
DUE TO (OR AS A CONSEQUENCE OF):
b. RESPIRATORY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
c. NEAR DROWNING
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate interval Between Onset and Death | | | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY
(Month, Day, Year)
MAY 1987 | | 28b. TIME OF INJURY
unknown M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED
left unattended at bathtub | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
at home | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
1621 Viney BALTIMORE | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Kustina Blotny MD (K. Blotny) | | | | 29c. LICENSE NUMBER
D 41601 | | 29d. DATE SIGNED (Month, Day, Year)
2-13-97 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
K. Blotny 1709 W. Rogers Ave BALTIMORE MD 21209 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
2-13-97 | | 32. REGISTRAR'S SIGNATURE
FEB 14 1997 Julia Davidson-Rodale | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THIS HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

97 04368

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOSEPH L. POWLEY | | | | 2. DATE OF DEATH
MONTH DAY YEAR
February 13, 1997 | | | | 3. TIME OF DEATH
9:45 AM | |
| 4. SOCIAL SECURITY NUMBER
235-44-4417 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
67 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
10/21/29 | | 8. BIRTHPLACE (State or Foreign Country)
Morgantown, W.V. | |
| 9a. FACILITY NAME (If not institution, give street and number)
1802 Prindle Drive -residence | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Bel Air, Maryland | | | | 9c. COUNTY OF DEATH
Harford | |
| 10a. STATE
Maryland | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Bel, Air | | | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
1802 Prindle Drive | | | | 10f. ZIP CODE
21015 | | 10g. CITIZEN OF WHAT COUNTRY?
United States | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
Korean Conflict | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify:
WHITE | | | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (9-12) College (1-4 or 5+)
12 YRS. | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
Telephone installer-repair | | | | 16b. KIND OF BUSINESS/INDUSTRY
Telephone A.T.& T. | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Francis V. Powley | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Edith G. Bumbarger | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Mary J. Moudry Powley | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1802 Prindle Drive, Bel Air, Maryland 21015 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Highview Memorial Garden | | 20c. LOCATION — City or Town, State
Fallston, Maryland | | 20d. DATE
Feb. 15, 1997 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
Evans Funeral Chapel-Bel Air, P.A.
3 Newport Drive Forest Hill, MD. 21050 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Non Smallcell Lung Cancer</u>
DUE TO (OR AS A CONSEQUENCE OF):
b. _____
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | Approximate Interval Between Onset and Death
8months | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | | | | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | 29b. SIGNATURE AND TITLE OF CERTIFIER
Joan P. Edwards M.D. | |
| 29c. LICENSE NUMBER
D31775 | | | | | | | | 29d. DATE SIGNED (Month, Day, Year)
2/13/97 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
2112 Bel Air Road, Suite 4A Fallston, Maryland 21047 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 14 1997 | | | | 32. REGISTRAR'S SIGNATURE
Julia Davidson-Russell | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RB

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04369

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Walter S. PIATEK

2. Date of Death

Month Day Year
February 9, 1997

3. Time of Death

8:53 PM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

218-01-8036

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 19, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1471 Reynolds Street

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

N/A

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Longshoreman

16b. Kind of Business/Industry

Shipping

17. Father's Name (First, Middle, Last)

Ignatius Piatek

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Jawieszewski

19e. Informant's Name/Relationship (Type, Print)

Helen P. Jarkowski / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 7th Avenue, Brooklyn Park, MD 21225

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holy Rosary Cem. February 13, 1997

Data

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Charles L. Steed's Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore, MD 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Complications of non Insulin dependent Diabetes years

Due to (or as a consequence of):

Ischemic Heart Disease years

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29e. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Horodyski, MD

29c. License number

AS2441614

29d. Date signed (Month, Day, Year)

February 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES HORODYSKI, MD, Harbor Hospital, 3001 S. Hanover St Balt, MD

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Coroner: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is well-posed and that the solution exists and is unique.

2. In the second part, the problem is solved for the case of a constant coefficient. The solution is obtained by the method of separation of variables.

3. In the third part, the problem is solved for the case of a variable coefficient. The solution is obtained by the method of variation of parameters.

4. In the fourth part, the problem is solved for the case of a non-linear coefficient. The solution is obtained by the method of perturbation.

5. In the fifth part, the problem is solved for the case of a non-local coefficient. The solution is obtained by the method of integral equations.

6. In the sixth part, the problem is solved for the case of a non-local coefficient. The solution is obtained by the method of integral equations.

7. In the seventh part, the problem is solved for the case of a non-local coefficient. The solution is obtained by the method of integral equations.

8. In the eighth part, the problem is solved for the case of a non-local coefficient. The solution is obtained by the method of integral equations.

9. In the ninth part, the problem is solved for the case of a non-local coefficient. The solution is obtained by the method of integral equations.

10. In the tenth part, the problem is solved for the case of a non-local coefficient. The solution is obtained by the method of integral equations.

The author wishes to express his appreciation to the Department of Mathematics, University of California, for the hospitality and facilities provided during his visit.

The author also wishes to thank the referee for his valuable suggestions and criticisms.

The author is indebted to the National Science Foundation for the support of this work.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04370

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Wayne Parker

2. Date of Death

February 11, 1997 7:45pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

267 Gibson Road

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

5. Social Security Number

212-38-7484

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 15, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

267 Gibson Road

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: 1961-1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Glass Company

17. Father's Name (First, Middle, Last)

Samuel Joseph Parker

18. Mother's Name (First, Middle, Maiden Surname)

Grace Skelly

19a. Informant's Name/Relationship (Type, Print)

Rosemary Parker/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

267 Gibson Road Pasadena, MD 21122

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

2/12/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Melanoma

Approximate Interval Between Onset and Death

5 weeks

Due to (or as a consequence of):

melanoma of unknown primary site

18 months

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gangster Nimmagadda

29c. License number

D39041

29d. Date signed (Month, Day, Year)

February 12th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAYATRI NIMMAGADDA 1600 S. Crain Highway South Glenburnie MD 21061

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Gangster Nimmagadda

State Registrar

Baltimore, Maryland 21215-0020

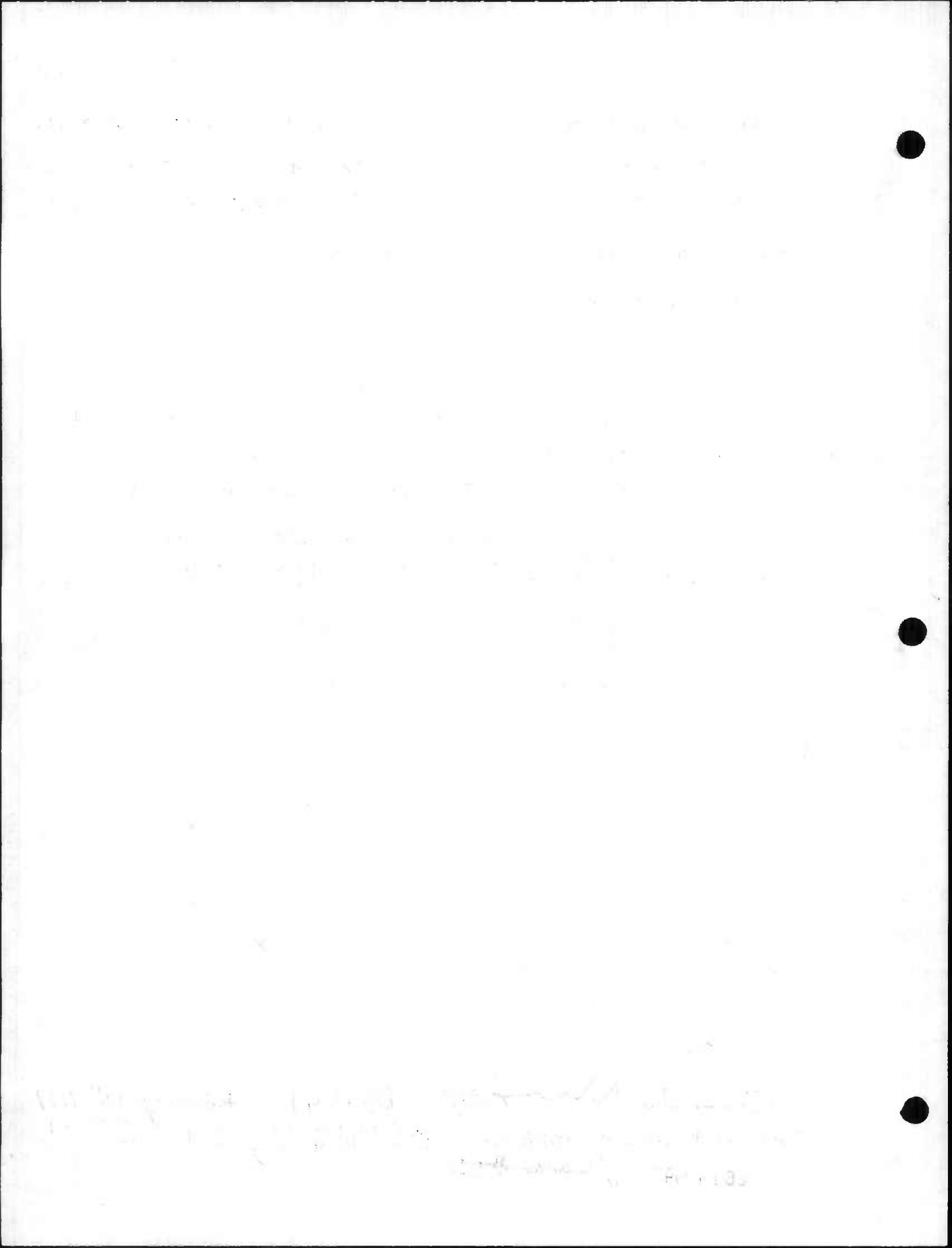
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04371

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Elma Posedenti

2. Date of Death

February 11, 1997

3. Time of Death

12:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4820 Vicky Road

4b. City, Town, or Location of Death

Perry Hall

4c. County of Death

Baltimore

5. Social Security Number

215-12-4324

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 7, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

406 W. 23rd Street

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In Own Home

17. Father's Name (First, Middle, Last)

Marvin Marston

18. Mother's Name (First, Middle, Maiden Surname)

Elma Bortle

19a. Informant's Name/Relationship (Type, Print)

Joseph J. Posedenti, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

504 Freeland Road Freeland, Maryland 21053

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Park

Date

2/14/97

20c. Location - City or Town, State

Eldersburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss Funeral Home

3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cancer of uterus & mets (breast)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SIPOUT + PE

Due to (or as a consequence of):

c. osteoarthritis

Due to (or as a consequence of):

d. DM / obesity

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08093

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Marguerite Moran, MD 3401 Mannasota Ave. Baltimore, Maryland

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04372

IYEM#26 PER PHYS. 2-14-97 FLM#G744 J.A.

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ANN FOX RING

2. Date of Death
Month Day Year
February 14, 19973. Time of Death
1:45 A.M.

4a. Facility Name (If not institution, give street and number)

Long Green Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

203-16-2407

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 8, 1912

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1443 Gorsuch Avenue

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Artist

18b. Kind of Business/Industry

Studio

17. Father's Name (First, Middle, Last)

Frank Fox

18. Mother's Name (First, Middle, Maiden Surname)

Mary Sabo

19a. Informant's Name/Relationship (Type, Print)

Richard Ochs

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1443 Gorsuch Avenue Baltimore, Maryland 21218

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

American Crematory

Date

2-22-97

20c. Location - City or Town, State

Warwick, Pennsylvania

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Wiedefeld Home
6500 York Road Baltimore, Maryland 21212

23a. Pert. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Disease
Due to (or as a consequence of):c. CVA
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Chronic Renal Failure

A. Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Betsy A. Fay MD

29c. License number

033220

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

3730 Falls Road Baltimore, Md 21211

Betsy A. Fay, M.D.

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04373

ITEMS: 23 part I, 27 per ME0 G-744 2/26/97 reb Certificate of Death

Reg. No.

| | | | | | |
|-------------------------------------|--|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DENISE E RICHARD | | 2. Date of Death
Month Day Year
FEBRUARY 11, 1997 | | 3. Time of Death
23:07 PM |
| | 4a. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE HOSPITAL | | 4b. City, Town, or Location of Death
Rose dale | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
213-62-1390 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
42 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Jan. 23, 1955 | | 9. Birthplace (State or Foreign Country)
MD | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Rose dale |
| | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
3 Manger Ct. apt. 3C | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
U.S.A |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4or 5+)
4+ | | |
| | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Human Service Director Retirement Center | | 16b. Kind of Business/Industry | | |
| | 17. Father's Name (First, Middle, Last)
William Frisby | | 18. Mother's Name (First, Middle, Maiden Surname)
Naomi Morton | | |
| | 19a. Informant's Name/Relationship (Type, Print)
David Richard / husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Manger Ct. apt. 3C Balto, MD 21237 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park | | 20c. Location - City or Town, State
Randallstown, MD |
| | 21. Signature of Funeral Service Licensee
James A. Morton | | 22. Name and Address of Facility
James A. Morton & Sons Funeral Home
1701 Laurens St. Balto., MD 21217 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
Dennis J. Chute, MD | | 29c. License number
OCME | | 29d. Date signed (Month, Day, Year)
FEBRUARY 12, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
Julia [Signature] | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04374

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET

2. Date of Death

Feb. 9 1997

3. Time of Death

5:10 AM

4a. Facility Name (If not institution, give street and number)

3224 Brendan Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

175-10-7164

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 1, 1911

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3224 Brendan Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Howard Oscar Livingston

18. Mother's Name (First, Middle, Maiden Surname)

Mimmie M. Rohler

19a. Informant's Name/Relationship (Type, Print)

Gale Lengrand (Cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2519 Lodge Forest Drive, Edgemere, Maryland 21219

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

20c. Location - City or Town, State

2-12

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home
3331 Brehms Lane, Baltimore, Maryland 2121323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Inanition

Due to (or as a consequence of):

3 months

b. biliary obstruction

Due to (or as a consequence of):

2 months

c. primary carcinoma of gall bladder

Due to (or as a consequence of):

1 year

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Richey

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Hospice

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D 13006

29d. Date signed (Month, Day, Year)

10 Feb 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Thomas Powell 101 W. Read St. Baltimore 21201

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21268-0760To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

6

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04375

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAY

S.

RAMEY

2. Date of Death

Month

Day

Year

February 12 97

3. Time of Death

14:03

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-36-7696

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN. 2 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1719 Light Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife Domestic

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

Harry Wood

18. Mother's Name (First, Middle, Maiden Surname)

Emma Moon

19a. Informant's Name/Relationship (Type, Print)

Charles Swaggerty/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1719 Light Street Baltimore, Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

FEB 17
1997

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home of South Balto.
130 E. Fort Ave. Baltimore, Md. 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. BRAIN DEATH

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Six hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. MASSIVE INTRA CRANIAL BLEED

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION

LONG STANDING HYPERTENSION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
8 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

HOUSE STAFF

29c. License number

AS 2441614-60

29d. Date signed (Month, Day, Year)

February 12, 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ATHIR J. MEROGE HARBOR HOSPITAL CENTER 3001 S. Hanover St.

31. Date filed (Month, Day, Year)

FEB 14 1997

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled out by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04376

Certificate of Death

Reg. No.

| | | | | | | | | | |
|---|---|---|---|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANDREW SZYMANSKI | | | | 2. Date of Death
Month 2 Day 7 Year 97 | | 3. Time of Death
6:30am | | |
| | 4a. Facility Name (If not institution, give street and number)
714 S. GLOVER STREET | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
215-05-2342 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
7-30-12 | 9. Birthplace (State or Foreign Country)
MARYLAND | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 10e. Street and Number
714 S. GLOVER STREET | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 8 YEARS College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
FISH MARKET | | 16b. Kind of Business/Industry
MARKET PLACE | | |
| | 17. Father's Name (First, Middle, Last)
JOHN SZYMANSKI | | | | 18. Mother's Name (First, Middle, Maiden Surname)
VICTORIA LEWANDOWSKI | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
MRS. CHRISTINE SZYMANSKI | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
714 S. GLOVER ST. BALTO. MD. 21224 | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLY CROSS P. N. C. C. | | Date
2-10-97 | 20c. Location - City or Town, State
BALTO. CO. MD. | | | |
| | 21. Signature of Funeral Service Licensee
<i>Charles B. Kaczorowski</i> | | | | 22. Name and Address of Facility
KACZOROWSKI FUNERAL HOME
2525 FLEET ST. BALTO. MD. 21224 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) <i>Pneumonia</i>
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | | Approximate Interval Between Onset and Death
<i>> 2 weeks</i> |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Arteriosclerotic Heart Disease</i> | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>Dr. J. J. Tano</i> | | 29c. License number
<i>011150</i> | | 29d. Date signed (Month, Day, Year)
<i>2/7/97</i> | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224</i> | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<i>FEB 14 1997</i> | | 32. Registrar's Signature
<i>Johnston</i> | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04377

Certificate of Death

Reg. No.

| | | | | | | | | | | | | |
|---|---|---|--|--|--|---|---|-----------------------------------|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Howard W. Schuder, JR. | | | | 2. Date of Death
Month Day Year
FEBRUARY 8 1997 | | | | 3. Time of Death
1:47pm | | | |
| | 4a. Facility Name (If not Institution, give street and number)
11104 GREENSPRING AVE. | | | | 4b. City, Town, or Location of Death
TIMONIUM | | | | 4c. County of Death
BALTIMORE | | | |
| Funeral
Director | 5. Social Security Number
219-22-9544 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
69 Yrs. | | 8. Date of Birth (Month, Day, Year)
JAN. 30, 1928 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | | |
| | Usual Residence of Decedent | | | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
TIMONIUM | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
11104 GREENSPRING AVE. | | 10f. Zip Code
21093 | | 10g. Citizen of What Country?
USA | | | | | | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 yrs College (1-4 or 5+) — | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CARPENTER | | 16b. Kind of Business/Industry
BAR HARBOR ARENA | | | | | | | | |
| 17. Father's Name (First, Middle, Last)
Howard W. Schuder, Sr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Lillian E. Wolf | | | | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Joan Schuder / wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11104 GREENSPRING AVE. TIMONIUM, MD. 21093 | | | | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVANS FUNERAL CHAPEL - BALTIMORE | | 20c. Location - City or Town, State
FOREST HILL, MARYLAND | | 20d. Date
FEB 13 1997 | | | | | | |
| 21. Signature of Funeral Service Licensee
[Signature] | | | | 22. Name and Address of Facility
EVANS CHAPEL OF CHURCH 2325 YORK RD. TIMONIUM, MD 21093 | | | | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
e. Lung Cancer
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
[Signature] | | 29c. License number
D37928 | | 29d. Date signed (Month, Day, Year)
February 10, 1997 | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
DR. ROBERT K. ROBY 2735 N. Charles St. Baltimore, Md 21218 | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | | | | | | | | | |
| 32. Registrar's Signature
[Signature] | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04378

Reg. No.

| | | | | | | | | | | |
|--|---|--|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HELEN SAVAGE | | | | | | 2. Date of Death
Month Day Year
February 8 1997 | | 3. Time of Death
1:24 PM | |
| | 4e. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | | | 4b. City, Town, or Location of Death
TIMONUM | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-40-8717 | | 8. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
54 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | Usual Residence of Decedent
10a. State
Maryland | | | | | | 10b. County
Hartford | | 10c. City, Town or Location
Bel Air | |
| To Be Completed by
Funeral Director | 10e. Street and Number
301 Cass Court | | | | | | 10f. Zip Code
21015 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S.
Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian,
Black, White, etc.
Specify: White | | | |
| To Be Completed by
Physician/Medical Examiner | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12)
12 YRS | | | | College (1-4 or 5+)
2 YRS | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
executive secretary | | 16b. Kind of Business/Industry
construction | |
| | 17. Father's Name (First, Middle, Last)
Joseph C. Gardini | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Margaret A. Shauck | | | |
| To Be Completed by
Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)
KRISTINE MORENO / daughter | | | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1405 Knicht Ave, Baltimore, Md 21227 | | | |
| | 20e. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of
cemetery, crematory or other place)
Evans Funeral Chapel - Bel Air | | Date
FEB 12 1997 | | 20c. Location - City or Town, State
Forest Hill, Maryland | | | |
| To Be Completed by
Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
 | | | | | | 22. Name and Address of Facility
Evans Chapel of Memories
8800 Harford Rd. Baltimore, Md 21234 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. BRAIN METASTASES
Due to (or as a consequence of):
LUNG CANCER
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death
months
months | | | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | |
| To Be Completed by
Physician/Medical Examiner | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Kendall Faulkner | | 29c. License number
D25643 | | 29d. Date signed (Month, Day, Year)
2/8/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
K R Faulkner MD / 2300 Dulany Valley Rd / Baltimore MD 21204 | | | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
 | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04379

Reg. No.

| | | | | | | | | | | |
|--|---|---|--|---|--|---|--------------------------------|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Aileen Singleton</i> | | | | 2. Date of Death
Month <i>February</i> Day <i>10</i> Year <i>1997</i> | | | | 3. Time of Death
<i>12:18</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>Northwest Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Randallstown</i> | | | | 4c. County of Death
<i>Baltimore</i> | |
| Funeral
Director | 5. Social Security Number
<i>578-26-4010</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>92</i> Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | 8. Date of Birth
(Month, Day, Year)
<i>9-8-1904</i> | | 9. Birthplace (State or Foreign Country)
<i>S.C.</i> | | Usual Residence of Decedent | | 10a. State
<i>MD</i> | | 10b. County
<i>NA</i> | |
| 10c. City, Town or Location
<i>Baltimore</i> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
<i>1838 W. Franklin Street</i> | | 10f. Zip Code
<i>21223</i> | | 10g. Citizen of What Country?
<i>U.S.A</i> | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>Black</i> | | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <i>8th grade</i> College (1-4 or 5+) <i>NA</i> | | |
| 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
<i>Waitress</i> | | 16b. Kind of Business/Industry
<i>Restaurant</i> | | 17. Father's Name (First, Middle, Last)
<i>Cornelius Taylor</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Bessie Carolia</i> | | 19a. Informant's Name/Relationship (Type, Print)
<i>Frances Taylor - Niece</i> | | |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3521 Millvale Road Woodlawn, Md 21244</i> | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Arbutus Mem Park</i> | | 20c. Date
<i>2-15-97</i> | | 20d. Location - City or Town, State
<i>Arbutus, Md</i> | | |
| 21. Signature of Funeral Service Licensee
<i>Gladys Wanner</i> | | 22. Name and Address of Facility
<i>March F.H. West
4300 Wabash Avenue Baltimore, Md 21215</i> | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. <i>Respiratory failure</i>
Due to (or as a consequence of):

b. <i>Aspiration pneumonia</i>
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____ | | Approximate Interval Between Onset and Death | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<i>M</i> | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<i>H. H. H. H.</i> | | 29c. License number
<i>H 45974</i> | | 29d. Date signed (Month, Day, Year)
<i>February 10, 1997</i> | | | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
<i>Hsieh, Alice Northwest Hospital Randallstown</i> | | 31. Date filed (Month, Day, Year)
<i>FEB 14 1997</i> | | 32. Registrar's Signature
<i>Gina Davidson-Randall</i> | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04380

| | | | | | | | | | |
|--|---|---|--|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Nathanial Covington Scotten | | | | 2. Date of Death
Month Feb Day 13 Year 1997 | | 3. Time of Death
1120 | | |
| | 4a. Facility Name (If not institution, give street and number)
4874 Church Lane | | | | 4b. City, Town, or Location of Death
Galesville | | 4c. County of Death
AA | | |
| Funeral
Director | 5. Social Security Number
214-03-5529 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
79 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAR 4, 1917 | | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Anne Arundel | | 10c. City, Town or Location
Galesville | | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
4874 Church Lane | | 10f. Zip Code
20765 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Waterman | | 16b. Kind of Business/Industry
Seafood/Commercial Fishing | | | | | |
| 17. Father's Name (First, Middle, Last)
Nathanial Covington Scotten, Jr. | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Emma Elizabeth Pennington | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Colleen Smith Scotten/wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4874 Church Ln. Galesville, MD 20765 | | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 2/14/97 | | 20c. Location - City or Town, State
Baltimore, MD | | | | | |
| 21. Signature of Funeral Service Licensee
George E. MacNabb | | | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wound Head
Due to (or as a consequence of):

b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
Minutes | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peripheral Vascular Disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year)
2/13/97 | | 28b. Time of Injury
UNK M | |
| | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred
Shot self. | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Galesville, md. | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner | | 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
William R. Jones MD | | 29c. License number
D06054 | |
| | | 29d. Date signed (Month, Day, Year)
2/13/97 | | 30. Name and address of person who complained cause of death (Item 23a) (Type, Print)
William R. Jones, MD 695 America 21038 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
John Anderson-Randall | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

97 04381

Item: 10e per F.H. G-744 2/14/97 reb

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HIRAM J. SMOOT, SR.

2. Date of Death

Month Day Year
FEBRUARY 11 1997

3. Time of Death

2230 PM

4a. Facility Name (If not institution, give street and number)

MERCY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

217-12-0618

6. Sex

XX M 2□ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 5 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X□ Yes 2□ No

10e. Street and Number

600 LIGHT ST. APT. 434

~~1646 S. Charles Street~~

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2X Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1□ Yes 2X No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Trucking Co.

17. Father's Name (First, Middle, Last)

Charles J. Smoot

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Donahue

19a. Informant's Name/Relationship (Type, Print)

Sharon L. Zitzer/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 E. 26th Street Baltimore, Md. 21218

20a. Method of Disposition

X□ Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Mem. Park

Date

FEB. 15 1997

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

Daniel A. Taylor

22. Name and Address of Facility

McCully Funeral Home of South Balto.

130 E. Fort Ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1X Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2X No

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1□ Inpatient

2X Outpatient

3□ DOA

26. Place of Death (Check only one)

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1X Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending investigation

6□ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joel Meshulam MD

29c. License number

D38675

29d. Date signed (Month, Day, Year)

2/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

J. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04382

Certificate of Death

Reg. No.

| | | | | | |
|---|---|---|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MARTHA STRICKLAND | | 2. Date of Death
Month FEBRUARY Day 7 Year 1997 | | 3. Time of Death
6 AM |
| | 4a. Facility Name (If not institution, give street and number)
HARBOR HOSPITAL CENTER | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
419-36-2162 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Jan. 31, 1929 | | 9. Birthplace (State or Foreign Country)
Alabama | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
Baltimore |
| | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
1444 Decatur Street | | 10f. Zip Code
21230 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Taxi driver | | 16b. Kind of Business/Industry
Transportation | | |
| | 17. Father's Name (First, Middle, Last)
Charles Robert Strickland | | 18. Mother's Name (First, Middle, Maiden Surname)
Mattie Strickland Watson | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ann Strickland/Sister | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
213 Micolas Ave., Opt, Alabama 36467 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Date | | 20c. Location - City or Town, State |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
a. EXACERBATION OF COPD | | | | 20 Yrs |
| | Due to (or as a consequence of):
b. ADENOCARCINOMA OF LUNG | | | | 1 MONTH |
| | Due to (or as a consequence of):
c. METASTATIC BRAIN DISEASE | | | | 2 WEEKS |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ASTHMA, Renal Stones | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier
RESIDENT PG 411 | | 29c. License number
AS 2441614-19 | | 29d. Date signed (Month, Day, Year)
February 7, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BINU CHACKO, 30015 HANOVER ST BALTIMORE MARYLAND | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
[Signature] | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04383

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GUY SELDNER SEILER

2. Date of Death

Month Day Year
FEB. 10, 1997

3. Time of Death

1054 P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3614 HOWARD PARK AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number

213-05-4411

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)
Feb. 16, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8 Holshire Court

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

2 yrs

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Coppersmith

16b. Kind of Business/Industry

Metal

17. Father's Name (First, Middle, Last)

William Austin Seiler

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Kebler

19a. Informant's Name/Relationship (Type, Print)

Clark Seiler / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

175 Gulf Ridge Road Reinholds PA. 17569

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gardens of Faith Cemetery 2/14/97 Rossville Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connolly Funeral Home of Essex
300 Mace Ave. Baltimore Md. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy

performed?
INSPECTION☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☒ Yes ☐ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

FEB. 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAVID R. FOWLER MD. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

David R. Fowler

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Hospital or Attending Physician: The law requires that the death certificate be executed
within 72 hours after death.
To Funeral Director: After this certificate has been signed by the attending physician and
the funeral director, page 2 should be detached for use as the burial-transit
certificate.State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04384

Item 2, 24a, per M.D. G-744 2/14/97 reb

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Lillian Schaller | | 2. Date of Death
Month FEB. Day 06 Year 1997 | | 3. Time of Death
11:40 pm |
| | 4e. Facility Name (If not institution, give street and number)
Good Samaritan Hospital | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A |
| Funeral
Director | 5. Social Security Number
215-18-6509 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Oct. 6, 1910 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
N/A |
| | 10c. City, Town or Location
Baltimore City | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
6116 Belair Road | | 10f. Zip Code
21206 | | 10g. Citizen of What Country?
U.S.A. |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
8th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Domestic Worker |
| | 16b. Kind of Business/Industry
Household | | 17. Father's Name (First, Middle, Last)
Unknown | | 18. Mother's Name (First, Middle, Maiden Surname)
Mary Elizabeth Keil |
| | 19. Informant's Name/Relationship (Type, Print)
Carolyn L. Rada/Daughter | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4207 Bayonne Avenue, Baltimore, Maryland 21206 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Location - City or Town, State
Beltsville, Maryland |
| | 21. Signature of Funeral Service Licensee
Guanta R Thomas | | 22. Name and Address of Facility
John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206 | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | e. Pneumonia
Due to (or as a consequence of): | | Approximate
Interval Between
Onset and Death |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. Diabetes Mellitus
Due to (or as a consequence of): | | |
| | | | c.
Due to (or as a consequence of): | | |
| | | | d.
Due to (or as a consequence of): | | |
| | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
John C. Miller M.D. | | 29c. License number
P10584 | | 29d. Date signed (Month, Day, Year)
January 06, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John C. Miller GSH 5601 Loch Raven Baltimore, M.D. 21239 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
John C. Miller | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04385

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VICTORIA V TURLEY

2. Date of Death

Month

FEB

Day

11

Year

1997

3. Time of Death

9:30AM

4a. Facility Name (If not institution, give street and number)

Saint AGNES HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

181-05-8755

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 1, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

HOWARD

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5005 ILCHESTER Rd

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

—

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

Peter KLINISTSKI

18. Mother's Name (First, Middle, Maiden Summa)

Pauline M. Dabalavider

19a. Informant's Name/Relationship (Type, Print)

Alfred P. TURLEY / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5005 ILCHESTER Rd. Ellicott City, Md 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

DULANEY Valley Mem Gdn

Date

FEB 17

1997

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Chapel of Chimes 2325 York Rd. Timonium Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

cor pulmonale

Due to (or as a consequence of):

obesity

Due to (or as a consequence of):

Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

>10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 21928

29d. Date signed (Month, Day, Year)

Feb 11th/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEONEL Barahona 1101 Maiden Choice La Baltimore, Md. 21042

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Physician
/ Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Essie M wooden

2. Date of Death
Month Day Year

February 10 1997

3. Time of Death

9:40 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

445-28-2498

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-19-1929

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3701 Milford Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th grade

5 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Barton Wooden

18. Mother's Name (First, Middle, Maiden Surname)

Annie Flynn

19a. Informant's Name/Relationship (Type, Print)

Barton Wooden-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3701 Milford Avenue Baltimore, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Therese B. Harris

22. Name and Address of Facility

Manor F.H. West 4300 Wabash Avenue Baltimore, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. left lobe pneumonia

Due to (or as a consequence of):

b. cerebral vascular accident

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1-2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Therese B. Harris MD

29c. License number

AS2402321/H.D. / 9006

29d. Date signed (Month, Day, Year)

February 10 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hien Dao Sinai Hospital

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

Davidson-Rodriguez

State Registrar

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0680

38

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04387

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JULIA WEBB | | | | 2. Date of Death
Month Day Year
FEBRUARY 11 1997 | | 3. Time of Death
0745 | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
172-38-1690A | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
112 Yrs. | 8. Date of Birth (Month, Day, Year)
Nov. 29, 1884 | 9. Birthplace (State or Foreign Country)
Delaware | | | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
N/A | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
4017 Liberty Heights Ave. | | | 10f. Zip Code
21207 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Private Family | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Charles Dunston | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ida Dunston | | | | |
| | 19a. Informant's Name/Relationship (Type, Print) (Friend)
Ms. Matilda Taylor | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6109 Robin Hill Rd. Balto. Md. 21207 | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn | | 20c. Location - City or Town, State
2/17/97 Balto. Md. | | | |
| | 21. Signature of Funeral Service Licensee
Joseph L. Russ | | | 22. Name and Address of Facility
Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 21216 | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

SEVERE HYPERNATREMIA
Due to (or as a consequence of):
VOLUME DEPLETION
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| State Registrar | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
C. NAIM, M.D. | | 29c. License number
D37333 | | 29d. Date signed (Month, Day, Year)
FEBRUARY 11, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
C. NAIM, M.D., BALTO. MD 21133 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04388

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|---|---|--|--------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CAROLYN C. WOLF | | | | 2. Date of Death
Month Day Year
2-13-97 | | 3. Time of Death
1:28 AM | | |
| | 4a. Facility Name (If not institution, give street and number)
8049 WYNBROOK RD. | | | | 4b. City, Town, or Location of Death
BALTO. | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
213-09-5215 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
77 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
10-30-19 | | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 10e. Street and Number
6808 BANK STREET | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 YEARS
College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
PRESS OPER. | | 16b. Kind of Business/Industry
AM. CAN CO. | | | | |
| | 17. Father's Name (First, Middle, Last)
JOSEPH PITURA | | | | 18. Mother's Name (First, Middle, Maiden Surname)
JULIA SARA KIW | | | | |
| Physician
/Medical
Examiner | 19e. Informant's Name/Relationship (Type, Print)
MS. CAROLYN HENNINGER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8049 WYNBROOK AVENUE BALTO. MD. 21224 | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) ENTOMB. | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
OAK LAWN CEMETERY | | Date
2-18-97 | | 20c. Location - City or Town, State
BALTO. MD. | | |
| | 21. Signature of Funeral Service Licensee
Charles R. Kaczorowski | | | | 22. Name and Address of Facility
KACZOROWSKI FUNERAL HOME
1201 DUNDALK AVE. BALTO. MD. 21222 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Hepatic Failure
Due to (or as a consequence of):
b. Cirrhosis of Liver
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
27 years | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| State
Registrar | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| | 29b. Signature and title of certifier
Mayer Gordaty M.D. | | | | 29c. License number
027938 | | 29d. Date signed (Month, Day, Year)
2/13/97 | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Mayer Gordaty M.D. 795 Aqueduct Rd GB no 21061 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

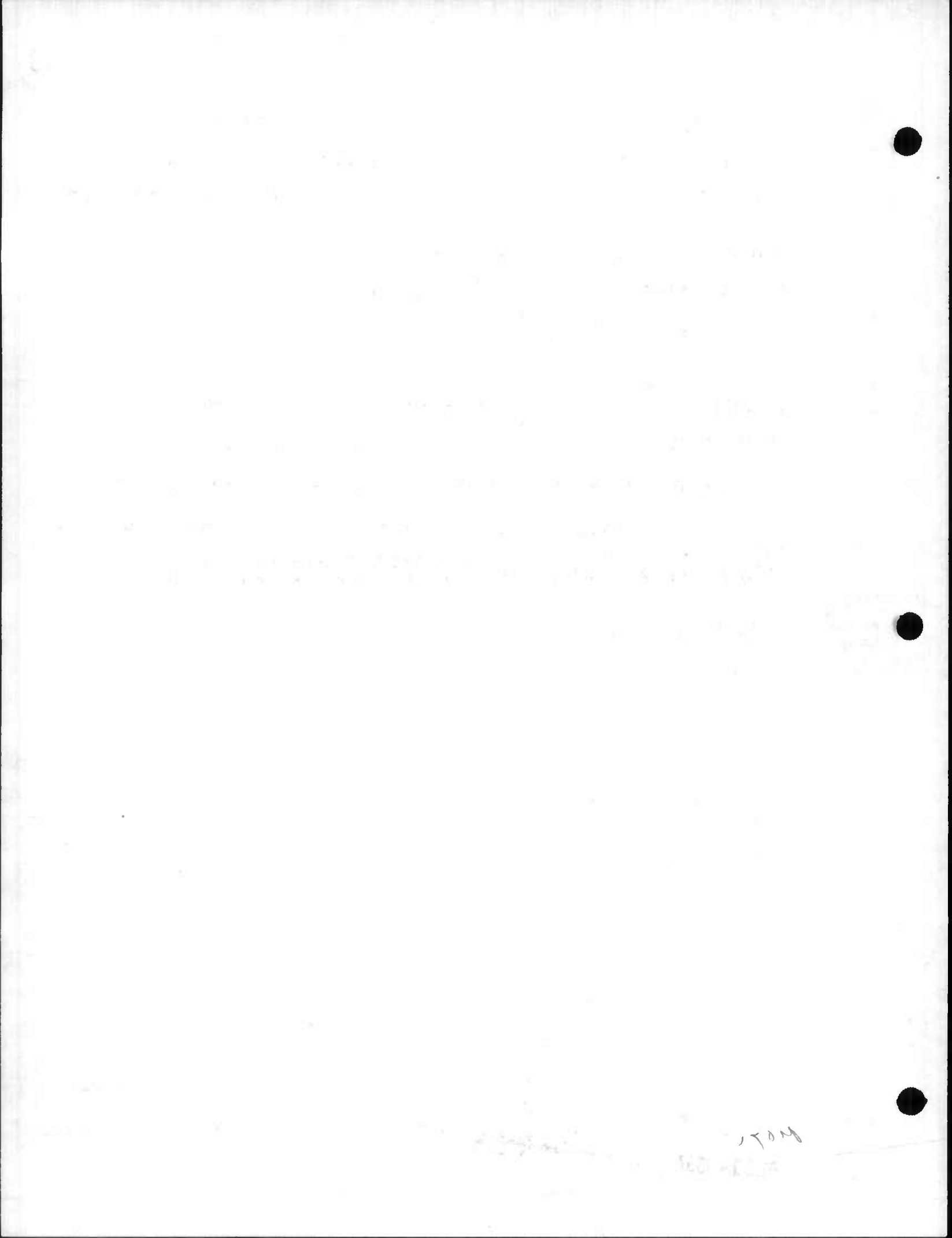
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State
Registrar



1501

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State of Maryland / Department of Health and Mental Hygiene

97 04389

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DORIS WISEMAN | | | | 2. Date of Death
Month February Day 4 Year 1997 | | 3. Time of Death
730 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Maryland General Hospital | | | | 4b. City, Town, or Location of Death
Baltimore City | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
212-36-3463 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
59 Yrs. | | 8. Date of Birth
(Month, Day, Year) 12-20-37 | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
MD | | 10b. County
Baltimore | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
420 Oldham St. | | 10f. Zip Code
21224 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 yrs. College (1-4 or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Disabled | | | | 16b. Kind of Business/Industry | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
David Hickman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Catherine Dean | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Mr. Steven Gaydosh, III | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
420 Oldham St. Baltimore, MD 21224 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Jesus | | 20c. Location - City or Town, State
12-10-97 Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
Charles B. Kaczorowski | | | | 22. Name and Address of Facility
Kaczorowski Funeral Home 1201 Dundalk Ave. Baltimore, MD 21222 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Hyperkalemia
Due to (or as a consequence of):
b. Shock secondary to Hemorrhage
Due to (or as a consequence of):
c. Uremia secondary to No Dialysis
Due to (or as a consequence of):
d. End Stage Renal Disease | | | | Approximate Interval Between Onset and Death | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | 27. Manner of Death
<input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| | 29b. Signature and title of certifier
Tehmina Kanwal, M.D. | | | | 29c. License number
89265 | | 29d. Date signed (Month, Day, Year)
2/4/97 | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a), (Type, Print)
Tehmina Kanwal, M.D. 40 Maryland General Hospital | | | | 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | |
| | 32. Registrar's Signature
Davidson | | | | 33. Registrar's Title
Registrar | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

97 04390

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Ruthetta E. Weitkamp | | | | 2. Date of Death
Month Day Year
February 11 1997 | | 3. Time of Death
3:50 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
20107 4261 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
76 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 10, 1920 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
PARKVILLE | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
42 BOURBON COURT | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 YRS. College (1-4 or 5+) COLLEGE | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
Home | | | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | 18. Mother's Name (First, Middle, Maiden Surname)
MARY HEIL | | 19a. Informant's Name/Relationship (Type, Print)
PAULA E. FRISITAG | | | |
| | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
42 BOURBON COURT PARKVILLE, MARYLAND 21234 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SPRING GROVE CEMETERY | | 20c. Location - City or Town, State
SPRING GROVE, PENN. | |
| | 21. Signature of Funeral Service Licensee
[Signature] | | 22. Name and Address of Facility
EVANS CHAPEL OF MEMORIES
8800 HARFORD ROAD - PARKVILLE | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. multi organ failure
Due to (or as a consequence of):</p> <p>b. Cardiogenic shock
Due to (or as a consequence of):</p> <p>c. Ventricular septal defect
Due to (or as a consequence of):</p> <p>d. Myocardial Infarction
Due to (or as a consequence of):</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p>13 days</p> <p>13 days</p> <p>13 days</p> <p>13 days</p> </div> </div> | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
Feb 11 1997 | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)
201 E. Univ. Pkwy. Baltimore, MD 21218 | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
[Signature] MD | | | | | | | | |
| 29c. License number
AT2438946 | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
February 11 - 1997 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bahaaddin Alsoufi | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | | | | | | | |
| 32. Registrar's Signature
[Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

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State of Maryland / Department of Health and Mental Hygiene

97 04391

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Aldona K. Williams | | | | 2. Date of Death
Month February Day 10 Year 1997 | | 3. Time of Death
11:00 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Manor Care / Rossville | | | | 4b. City, Town, or Location of Death
Rosedale | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
198 18 7762 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
75 Yrs. | | 8. Date of Birth (Month, Day, Year)
July 4 1921 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Sparks | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
99 Far Corners Loop | | 10f. Zip Code
21152 | |
| | 10g. Citizen of What Country?
USA | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16. Kind of Business/Industry
Medical | | 17. Father's Name (First, Middle, Last)
Stiney Kasputis | |
| | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Office Clerk | | 19a. Informant's Name/Relationship (Type, Print)
John J. Williams | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
99 Far Corners Loop Sparks, Maryland 21152 | | 20. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial Gardens | | 20c. Location - City or Town, State
Timonium, Maryland | | 21. Signature of Funeral Service Licensee
Erin R. Kinn | | 22. Name and Address of Facility
Evans Chapel of Chimes
2325 York Rd. Timonium MD. 21093 | |
| | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. congestive heart failure
Due to (or as a consequence of):
b. atherosclerotic coronary disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
Kristine C. Saw | |
| | 29c. License number
D45904 | | 29d. Date signed (Month, Day, Year)
February 12, 1997 | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
KRISTINE C. SAW 9524 BELAIR BALTIMORE 21236 | | 31. Date filed (Month, Day, Year)
FEB 14 1997 | |
| 32. Registrar's Signature
John H. Wilson | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04392

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)
MARGARET ANNA WOJTKOWIAK | | 2. Date of Death
Month FEBRUARY Day 9 Year 1997 | | 3. Time of Death
6:25 PM | |
| 4a. Facility Name (If not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER | | | 4b. City, Town, or Location of Death
TOWSON, MARYLAND | | 4c. County of Death
BALTIMORE |
| 5. Social Security Number
220-09-4020 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
83 Yrs. | 8. Date of Birth (Month, Day, Year)
Sept. 4, 1913 | 9. Birthplace (State or Foreign Country)
Maryland | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Parkville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
2412 Bradford Rd. | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) — | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Home | |
| 17. Father's Name (First, Middle, Last)
Edward Heinbuch | | | 18. Mother's Name (First, Middle, Maiden Surname)
Annie Miller | | |
| 19a. Informant's Name/Relationship (Type, Print)
Pat Huneke / daughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2412 Bradford Rd. Parkville, Md 21234 | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Mary | | 20c. Location - City or Town, State
Dundalk, Md. | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Evans Chapel of Memories
8800 Hartford Rd. Baltimore, Md 21234 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ACUTE MYOCARDIAL INFARCTION
a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
GASTRO INTESTINAL BLEEDING | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D37254 | | 29d. Date signed (Month, Day, Year)
2-9-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
 | | | |

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04393

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Esther D. Witherite

2. Date of Death

Feb. 12 1997

3. Time of Death

11:00AM

4a. Facility Name (If not Institution, give street and number)

1513 Baldwin Mill Rd.

4b. City, Town, or Location of Death

Jarrettsville

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

172-16-2149

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 28, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State
Maryland

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1513 Baldwin Mill Rd.

10f. Zip Code

21084

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John Beers

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Pusey

19a. Informant's Name/Relationship (Type, Print)

Harold L. Witherite

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1513 Baldwin Mill Road Jarrettsville Mo. 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

Feb. 15 1997

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Director

[Signature]

22. Name and Address of Facility

Evans Funeral Chapel - Bel Air
3 Newport Dr. Forest Hill, Md. 2105023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Chronic Obstructive Lung Dx

Approximate
Interval Between
Onset and Death

years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D324053

29d. Date signed (Month, Day, Year)

February 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Mark Lamos 3346 Paper Mill Rd. Phoenix, Md.

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital-Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04394

Reg. No.

| | | | | | |
|--|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BRANDON WITHERSPOON | | 2. Date of Death
Month Day Year
FEBRUARY 10, 1997 | | 3. Time of Death
10:26 P.M. |
| | 4a. Facility Name (If not institution, give street and number)
2863 N. EDGECOMBE CIRCLE | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
NA |
| Funeral
Director | 5. Social Security Number
212-88-5273 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
23 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
10-30-1973 | | 9. Birthplace (State or Foreign Country)
MD | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
NA | | 10c. City, Town or Location
Baltimore |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
2863 N. Edgcombe Circle | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
U.S.A |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown College (1-4 or 5+) NA | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Unemployed | | 16b. Kind of Business/Industry
NA |
| | 17. Father's Name (First, Middle, Last)
Charles Witherspoon | | 18. Mother's Name (First, Middle, Maiden Surname)
Barbara Hopewell | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Barbara Witherspoon-Mother | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2863 N. Edgcombe Circle Balto MD 21215 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cem | | 20c. Location - City or Town, State
2-17-97 Baltimore, MD |
| | 21. Signature of Funeral Service Licensee
Plym B. Harris | | 22. Name and Address of Facility
March F.H. West 21215
4300 Wabash Avenue Balto, MD | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | |
| Immediate Cause (Final disease or condition resulting in death)
e. Multiple Gun Shot Wounds
Due to (or as a consequence of): | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide | | | | | |
| 28a. Date of Injury (Month, Day, Year)
2-10-97 28b. Time of Injury
2212 M 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred
subject shot | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Residence 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2863 N. Edgcombe Circle | | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
[Signature] 29c. License number
O.C.M.E. 29d. Date signed (Month, Day, Year)
FEBRUARY 11, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 32. Registrar's Signature
[Signature] | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97-04395

Certificate of Death

Reg. No.

| | | | | | | | |
|---|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
EVA MAE WHITEMAN | | | 2. Date of Death
Month FEB. Day 11 Year 1997 | | 3. Time of Death
1:25 AM | |
| | 4a. Facility Name (If not institution, give street and number)
GENSIS ELDER CARE PERRING PARKWAY | | | 4b. City, Town, or Location of Death
PARKVILLE | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
219-07-1839 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
11/9/12 | 9. Birthplace (State or Foreign Country)
MARYLAND |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MARYLAND | 10b. County
BALTIMORE | 10c. City, Town or Location
PARKVILLE | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
3134 WILLOUGHBY ROAD | | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8TH GRADE
College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | |
| | 17. Father's Name (First, Middle, Last)
WILLIAM E. HELMS | | | 18. Mother's Name (First, Middle, Maiden Surname)
ELSIE ENSOR | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
CHARLES WHITEMAN, JR. HUSBAND | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3134 WILLOUGHBY ROAD BALTIMORE, MD 21234 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
METRO CREMATORY, INC. | | Date
2/14/97 | 20c. Location - City or Town, State
CATONSVILLE, MD | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC Arrhythmia
Due to (or as a consequence of):
b. Atherosclerosis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.
Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
10 min
20 yr |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D44604 | | 29d. Date signed (Month, Day, Year)
2/11/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL D. SUTER, MD 8100 HARFORD ROAD BALTIMORE, MD 21234 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 14 1997 | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

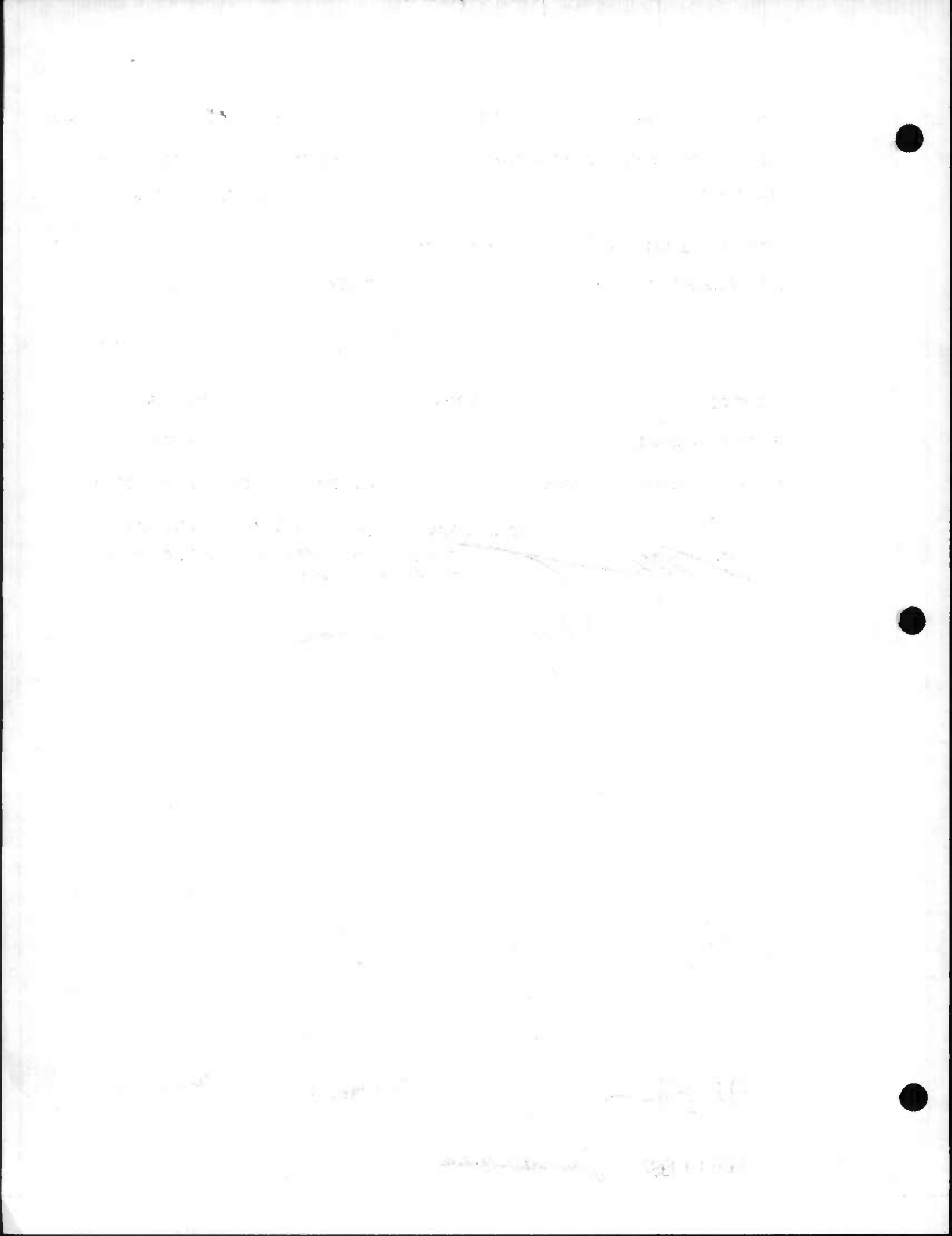
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04396

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Cecelia E. Young

2. Date of Death

February 9 1997

3. Time of Death

9:15pm

4a. Facility Name (If not institution, give street and number)

Franklin Woods

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-14-4801

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 11, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

Baltimore

10c. City, Town or Location

CARNEY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3328 Summit Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 yrs

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William F. Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth V. Tayman

19a. Informant's Name/Relationship (Type, Print)

Merle C. Young / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3328 Summit Ave. Carney, Md. 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel - Air

Date

Feb 10 1997

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Chapel of Memories
8800 Harford Rd Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerosis

Due to (or as a consequence of):

10 yr

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DM Hypertension

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44604

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Michael Suter 8100 Harford Rd. Baltimore, Md 21234

31. Date filed (Month, Day, Year)

FEB 14 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04397

Certificate of Death

Reg. No.

| | | | | | | | | | |
|--|---|--|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GREGORY ARCEO | | | | 2. Date of Death
Month Day Year
FEBRUARY 14 1997 | | 3. Time of Death
9:00 am | | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
309-80-0043 | 6. Sex
1 M 2 F | 7. Age (In yrs. last birthday)
27 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
Month Day Year
2/14/70 | | 9. Birthplace (State or Foreign Country)
Indiana | |
| | Usual Residence of Decedent | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Pennsylvania | 10b. County
N/A | 10c. City, Town or Location
Mechanicsburg | | | 10d. Inside City Limits
1 Yes 2 No | | | |
| | 10e. Street and Number
126 12 West Portland St. | | | 10f. Zip Code
17055 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 Never Married 2 Married
3 Widowed 4 Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: Puerto Rican | | 14. Race - American Indian, Black, White, etc.
Specify: Hispanic | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Craneman | | 16b. Kind of Business/Industry
Candy factory | | | | |
| | 17. Father's Name (First, Middle, Last)
Gilbert Arceo | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Cerida Martinez | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Gilbert Arceo Sr. (FATHER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6316 Wait St. Merrillville, Indiana 46410 | | | | |
| | 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Calumet Park | | Date
2/18 | | 20c. Location - City or Town, State
Merrillville Ind. | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Della Noce & Sons Funeral Home
322 S. High St. Baltimore 21202 Md. | | | | |
| | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and Death |
| | Immediate Cause (Final disease or condition resulting in death)
CEREBRAL EDEMA
Due to (or as a consequence of):
CEREBRAL ASPERGILLOSIS
Due to (or as a consequence of):
Due to (or as a consequence of):
Due to (or as a consequence of): | | | | | | | | Two weeks

Two weeks |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEPSIS | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown
2 No | |
| 24a. Was an autopsy performed?
1 Yes 2 No
2 No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No
2 No | |
| 25. Was case referred to medical examiner?
1 Yes 2 No
2 No | | | | 26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | |
| 27. Manner of Death
1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 Yes 2 No | | 28d. Describe how injury occurred | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29e. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| 29b. Signature and title of certifier
 FELLOW | | | | 29c. License number
RES-000 | | 29d. Date signed (Month, Day, Year)
February 14, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
ADNAN QURECHI NEUROCRITICAL CARE FEI | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
 | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed-in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04398

Items: 23 part I, 27 per MEO G-745 3/19/97 reb *Certificate of Death*

Reg. No.

| | | | | | | | | |
|--|--|---------------------------------------|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BENJAMIN HAROLD ALEXANDER | | | | 2. Date of Death
Month Day Year
FEBRUARY 10, 1997 | | 3. Time of Death
3:30 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
761 SILVER SPRING AVE | | | | 4b. City, Town, or Location of Death
SILVER SPRING | | 4c. County of Death
MONTGOMERY | |
| Funeral
Director | 5. Social Security Number
283-12-9193 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
75 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
OCT 18 1921 | 9. Birthplace (State or Foreign Country)
GA |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
OH | | 10b. County
HAMILTON | | 10c. City, Town or Location
CINCINNATI | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
1610 DEXTER | | | | 10f. Zip Code
45206 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5 | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
BUSINESS/ACADEMICS | | | 16b. Kind of Business/Industry
SELF-EMPLOYED | | |
| | 17. Father's Name (First, Middle, Last)
MONAH BUSH ALEXANDER | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNIE WILLIE FLOWERS | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
DREW ALEXANDER - SON | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7156 MANOR OAKS DR., DALLAS, TX 75248 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
WALNUT HILLS CEMETERY | | 20c. Location - City or Town, State
2-15 CINCINNATI, OH | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
STERLING ASHTON FUNERAL HOME, INC.
736 EDMONDSON AVE., BALT. MD 21228 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE [ASCVD]
Due to (or as a consequence of):

b. _____
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
FEBRUARY 11, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
 | | | | |

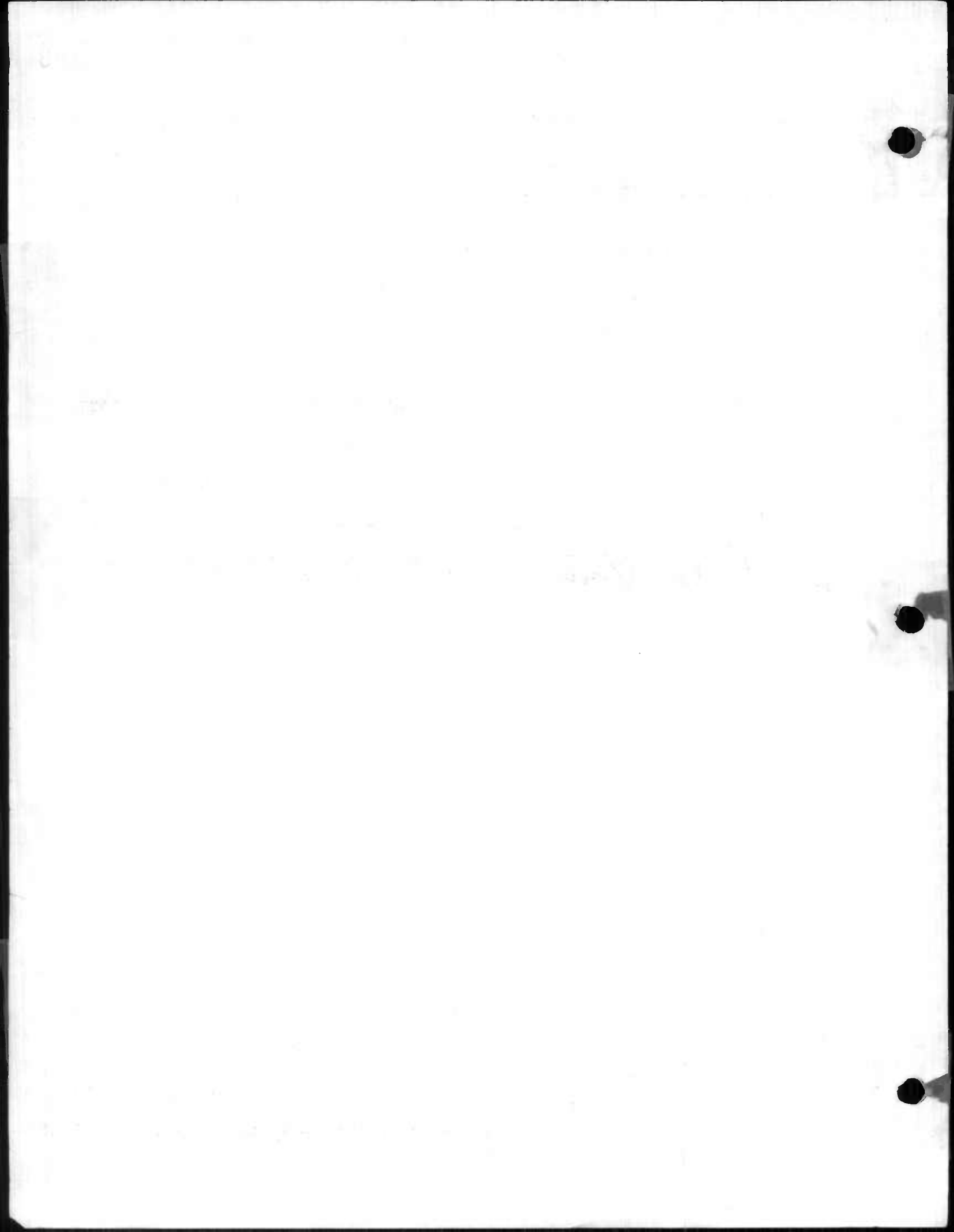
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04399

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lynda Rowe Armiger

2. Date of Death

February 17 1997 6:08pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Gulchrist 6601 N. Charles street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

218-32-7485

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG 2, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

Baltimore

10c. City, Town or Location

White Marsh

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16 Willow Path Court

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Public Library

17. Father's Name (First, Middle, Last)

Henry H. Rowe

18. Mother's Name (First, Middle, Maiden Surname)

Norma Lewis

19a. Informant's Name/Relationship (Type, Print)

Dona A. Mafale/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5316 Plymouth Rd. Baltimore, MD 21214

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 2/18/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Ovarian Cancer

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

6yrs

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) INPT/HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Rita Pabla MD

29c. License number

D47707

29d. Date signed (Month, Day, Year)

February 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA PABLA MD 6565 N Charles St Ste 203 Baltimore MD 21204

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

A. L. Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



AL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04400

Certificate of Death

Reg. No.

| | | | | | | | | | | |
|---|---|--|--|--|--|---|--|-----------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LEO A. BACHMAN | | | | 2. Date of Death
Month Day Year
FEB 8 1997 | | 3. Time of Death
4:20 PM | | | |
| | 4a. Facility Name (If not institution, give street and number)
NATIONAL NAVAL MEDICAL CENTER | | | | 4b. City, Town, or Location of Death
BETHESDA | | 4c. County of Death
MONTGOMERY | | | |
| Funeral
Director | 5. Social Security Number
230-48-8971 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
94 Yrs. | | 8. Date of Birth (Month, Day, Year) | | 9. Birthplace (State or Foreign Country)
Iowa | |
| | Usual Residence of Decedent | | | | 10a. State
Virginia | | 10b. County
Fairfax | | 10c. City, Town or Location
Vienna | |
| To Be Completed by Funeral Director | 10d. Inalde City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
1610 Hunter Mill Road | | 10f. Zip Code
22182 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WWII
If Yes, Give Year or Dates: Korea | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collega (1-4or 5+)
5+ | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
R Admiral | | 16b. Kind of Business/Industry
U.S. Navy | | | | | |
| | 17. Father's Name (First, Middle, Last)
Adolph Bachman | | | | 18. Mother's Name (First, Middle, Maiden Sumeme)
Nancy Cundiff | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Helen Barnes / Daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
117 Elm Pl. New Canaan, Ct. 06840 | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory | | Data
2/10/97 | | 20c. Location - City or Town, State
Alexandria, Va. | | | |
| | 21. Signature of Funeral Service Licensee | | | | 22. Name and Address of Facility
Ives-Pearson Funeral Homes
2847 Wilson Blvd. Arlington, Va. 22201 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Finet disease or condition resulting in death)
PNEUMONIA
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or es a consequence of):
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
DAYS | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | |
| 25. Was casa referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury et Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. | | 29b. Signature and title of certifier
Dominic de Kerat MD | | 29c. License number
0101-051231 (VA) | | 29d. Date signed (Month, Day, Year)
02/10/97. | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
D.R.DEKERATRY, LT, MC, USN | | | | NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600 | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
Julia Anderson-Radlett | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

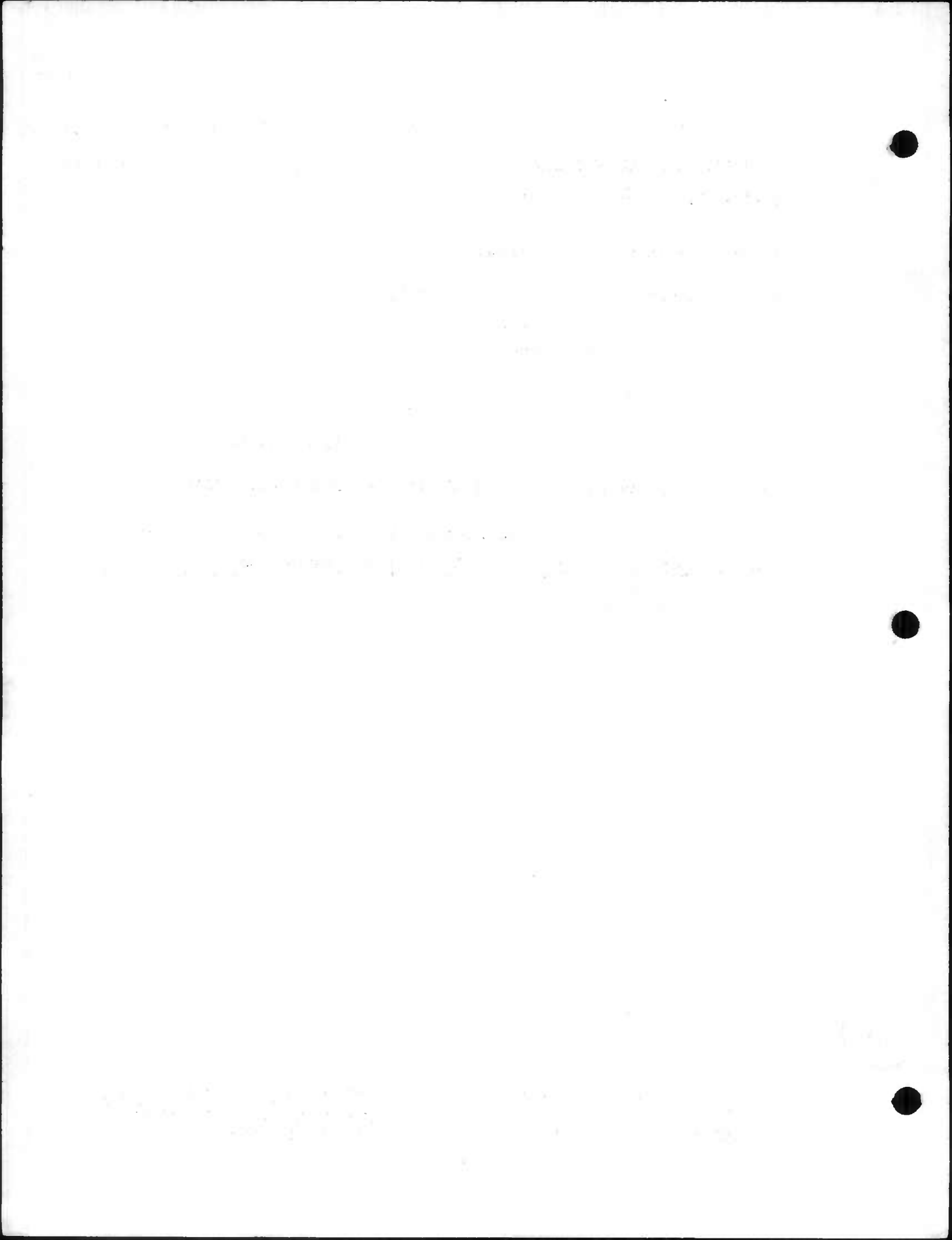
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04401

| | | | | | | | | | | |
|---|---|--|---|-------------------------------|--|--|--|-----------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Jeannette Marie Barlow | | | | | | 2. Date of Death
Month 02 Day 12 Year 97 | | 3. Time of Death
12:25 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
511 Academy Road | | | | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
217-22-1649 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
68 Yrs. | | 8. Date of Birth (Month, Day, Year)
11/13/1928 | | 9. Birthplace (State or Foreign Country)
MD | |
| | 10a. State
Md | | | | | | | | | |
| To Be Completed by Funeral Director | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| | 10e. Street and Number
511 Academy Road | | | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
USA | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8
College (1-4or 5+) 8 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Caterer | | | | 16b. Kind of Business/Industry
Food Service | | | |
| | 17. Father's Name (First, Middle, Last)
Clarence Crofoot | | | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Bianco | | | |
| | 19a. Intorment's Name/Relationship (Type, Print)
James Barlow /Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
511 Academy Road, Catonsville, Md 21228 | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park | | Data
2/15 | | 20c. Location - City or Town, State
Baltimore, Md. | | | |
| | 21. Signature of Funeral Service Licensee
<i>Edward A. Gregorich</i> | | | | 22. Name and Address of Facility
Sterling Ashton Funeral Home, Inc
736 Edmondson Avenue, Balto, Md 21228 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <i>metastatic pancreatic cancer</i>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Approximate Interval Between Onset and Death
2 months | | | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>John Oltman MD</i> | | 29c. License number
D40850 | | 29d. Date signed (Month, Day, Year)
February 12, 1997 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
YVONNE OTTAVIANO MD 900 CATON AVE. BALTIMORE MD 21227 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Medical or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be attached to the body of the decedent and returned to the funeral home for filing in the Department of Health and Mental Hygiene.

Medical Certification: To Be Completed by Physician/Medical Examiner

JA

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04402

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEON

BASKIN

2. Date of Death

Month Day Year
FEB. 14, 1997

3. Time of Death

6:30 PM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

207-34-5839

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JUNE 3, 1919

9. Birthplace (State or Foreign Country)

RUSSIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

831 SOUTH SHARP STREET

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

GEOLOGY

17. Father's Name (First, Middle, Last)

NOAH

BASKIN

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA

RABINOWITZ

19a. Informant's Name/Relationship (Type, Print)

LOUISA BASKIN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

831 SOUTH SHARP ST; BALTIMORE, MD 21230

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILLTOP SERVICE CORP. 2-17-96

Date

20c. Location - City or Town, State

TOWSON, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD, PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic Coronary Heart Disease

Due to (or as a consequence of):

29 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Henry I. Babitt, M.D.

29c. License number

D00337

29d. Date signed (Month, Day, Year)

February 15, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Henry I. Babitt, M.D. 1838 Greene Tree Rd Ste 535 Balto, Md 21208

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature] Julia Davidson

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020. The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04403

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Josephine Barber | | | | 2. Date of Death
Month Day Year
February 14 97 | | 3. Time of Death
4 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Liberty Medical Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-09-9301 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
88 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
09-10-08 | 9. Birthplace (State or Foreign Country)
Unknown |
| | Usual Residence of Decedent | | | | 10a. State
MD | | 10b. County
N/A | |
| To Be Completed by Funeral Director | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
2915 W. Coldspring Lane | |
| | 10f. Zip Code
21215 | | | | 10g. Citizen of What Country?
USA | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | |
| | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown College (1-4or 5+) N/A | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Unknown | | 16b. Kind of Business/Industry
Unknown | |
| | 17. Father's Name (First, Middle, Last)
Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Unknown | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Lillian Synder-guardian | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2915 Coldspring Lane Baltimore, MD 21215 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | 20c. Location - City or Town, State
2-15-97 Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
* Albert P. Ulye | | | | 22. Name and Address of Facility
Albert P. Ulye Funeral Home
638 N. Gilmer Street Baltimore, MD 21217 | | | |
| | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
pneumonia
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | |
| | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Hypertension, Anorexia, Dehydration, Coronary Artery disease | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, Anorexia, Dehydration, Hypertension, Coronary Artery disease | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | |
| 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | 28d. Describe how Injury occurred | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
[Signature] M.D. | | | | |
| 29c. License number
D33583 | | | | 29d. Date signed (Month, Day, Year)
February 14, 97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Hafeez Zubeed LMC | | | | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | |
| 32. Registrar's Signature
[Signature] | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04404

| | | | | | | | | |
|---|--|---|--|--|--|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
George E. Butler | | | | 2. Date of Death
Month February Day 13 Year 1997 | | 3. Time of Death
8:18 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rossville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
212-56-9688 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
45 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 7, 1951 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
227 Southeastern Ct. | | | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: 1969-73 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Service Manager | | 16b. Kind of Business/Industry
Automotive | | |
| 17. Father's Name (First, Middle, Last)
Leo Butler | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Jessie Lorraine Price | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Sharon Lee Butler (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
227 Southeastern Ct. Essex, Md. 21221 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Crematory 2/17/1997 | | Date
2/17/1997 | | 20c. Location - City or Town, State
Baltimore, Md. | | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Fibrillation
Due to (or as a consequence of):
b. Acute Myocardial Infarction
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | Approximate Interval Between Onset and Death
30 minutes |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
P. A. Baltazis M.D. | | 29c. License number
D 28949 | | 29d. Date signed (Month, Day, Year)
2/14/97 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Panayiotis Baltazis M.D. 1232 Race Road STE.202 Baltimore, Md. 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04405

| | | | | | | | | | | |
|--|--|---------------------------------------|---|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Emma E. Borman | | | | 2. Date of Death
Month Day Year
Feb. 14, 1997 | | | | 3. Time of Death
8:50 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Horizon Speciality Center | | | | 4b. City, Town, or Location of Death
Baltimore | | | | 4c. County of Death
N--A | |
| Funeral
Director | 5. Social Security Number
212-09-7005 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
83 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | |
| | Usual Residence of Decedent | | | | 8. Date of Birth (Month, Day, Year)
July 6, 1913 | | 9. Birthplace (State or Foreign Country)
Pennsylvania | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
6311 Brown Avenue | | | | 10f. Zip Code
21224 | | 10g. Citizen of What Country?
U.S.A. | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Assembly Worker | | | 16b. Kind of Business/Industry
Can Mfg. Co. | | |
| | 17. Father's Name (First, Middle, Last)
Rudolph Borman | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Frieda Wink | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Joseph Borman/Grandson | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
803 S. Belnord Ave., Balto., Md. 21205 | | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Date
2-17-97 | | 20c. Location - City or Town, State
Beltsville, Md. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bradley-Ashton Funeral Home, Inc.
2134 Willow Spring Rd., Balto., Md. 21222 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Renal failure
Due to (or as a consequence of):
b. Arteriosclerosis
Due to (or as a consequence of):
c. Atherosclerotic Vascular Disease
Due to (or as a consequence of):
d. | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how Injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D24276 | | | 29d. Date signed (Month, Day, Year)
2-14-97 | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Scalia 2801 Hudson St., Balto., Md. 21224 | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04406

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Florence Boisseau | | | | 2. Date of Death
Month Feb Day 13 Year 97 | | 3. Time of Death
07:50 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Bow Secours Hospital | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
220-12-8491 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
70 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 15, 1926 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by
Funeral Director | 10e. Street and Number
1737 BRADDOCK AVENUE | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: black | |
| To Be Completed by
Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NURSE | | 16b. Kind of Business/Industry
ASHBURN NURSING HOME | |
| | 17. Father's Name (First, Middle, Last)
UNKNOWN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
GERTRUDE | | | |
| To Be Completed by
Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
JAMES BOISSEAU / HUSBAND | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1737 BRADDOCK AVE BALTIMORE, MD 21216 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
MARYLAND NATIONAL MEMORIAL PK | | 20c. Location - City or Town, State
LAUREL MARYLAND | |
| To Be Completed by
Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Debra Harris | | | | 22. Name and Address of Facility
CHATHAM - HARRIS Funeral Home
5240 REISTERSTOWN ROAD
BALTIMORE, MARYLAND 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. Bradyarrhythmia
Due to (or as a consequence of):</p> <p>b. Respiratory Failure
Due to (or as a consequence of):</p> <p>c. Hypoxic encephalopathy
Due to (or as a consequence of):</p> <p>d. Bilateral pneumonitis - Septicemia</p> </div> </div> | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
acute Sinusitis with Septicemia
Hyperosmolar diabetic state | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To Be Completed by
Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by
Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| To Be Completed by
Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| | 29b. Signature and title of certifier
Dr. [Signature] | | | | 29c. License number
D18327 | | 29d. Date signed (Month, Day, Year)
2-14-97 | |
| To Be Completed by
Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Moges Gebremariam 4660 Wilkens Ave Balto 21229 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
[Signature] | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 4003.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04407

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gilbert James Berg Sr.

2. Date of Death

Feb. 12 1997

3. Time of Death

8:25am

4a. Facility Name (If not institution, give street and number)

3976 Gamber Road

4b. City, Town, or Location of Death

Finksburg

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

213-10-5551

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 16 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3976 Gamber Road

10f. Zip Code

21048

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Franklin Berg

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Whittington

19a. Informant's Name/Relationship (Type, Print)

Shirley Steedman (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3972 Gamber Rd. Finksburg MD 21048

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Mem. Gardens

Date

2/14/97

20c. Location - City or Town, State

Finksburg MD

21. Signature of Funeral Service Licensee

Brian L. Haight

22. Name and Address of Facility

Haight Funeral Home & Chapel
P.O. Box 195 Sykesville MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastrointestinal bleeding

10 days

Due to (or as a consequence of):

b. Gastric tumor, malignancy

2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eugene M.D.

29c. License number

D 40235

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ehoon K. Kim, MD, 210 Washington Height, Westminster, MD 21157

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital attending physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04408

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|--|--|--|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)
HERBERT JOHN BROWN JR. | | 2. Date of Death
Month FEB. Day 11 Year 1997 | | 3. Time of Death
11:12 PM | |
| 4a. Facility Name (If not institution, give street and number)
7709 BUCKHILL ROAD | | 4b. City, Town, or Location of Death
KINGSVILLE | | 4c. County of Death
BALTIMORE | |
| 5. Social Security Number
215-34-5494 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
59 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 27, 1937 |
| 9. Birthplace (State or Foreign Country)
Baltimore, Maryland | | | | | |
| Usual Residence of Decedent | | | | | |
| 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Kingsville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
7709 Buck Hill Road | | 10f. Zip Code
21087 | | 10g. Citizen of What Country?
U.S.A. | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: Unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | |
| 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th.
College (1-4 or 5+) n/a | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Insulator | | 16b. Kind of Business/Industry
Insul-Temp Airco | |
| 17. Father's Name (First, Middle, Last)
Herbert John Brown, Sr. | | 18. Mother's Name (First, Middle, Maiden Surname)
Gertrude M. Grapp | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Mrs. Theresa A. Brown (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7709 Buck Hill Road Kingsville, Md. 21087 | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Cemetery Feb. 15, 1997 | | 20c. Location - City or Town, State
Baltimore, Maryland | |
| 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
E. F. Lassahn Funeral Home
11750 Belair Road Kingsville, Md. 21087 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Arteriosclerotic Cardiovascular Disease
a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | Approximate Interval Between Onset and Death | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
INSPECTION
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
O.C.M.E | |
| 29d. Date signed (Month, Day, Year)
FEB. 13, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | |

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene

97 04409

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARJORIE BOND

2. Date of Death

Month

Day

Year

FEBRUARY

15

1997

3. Time of Death

0355

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Lorien Columbia Nursing & Rehab. Center
6334 Cedar Lane Columbia, Maryland 21045

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

218-22-6461

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month

Day

Year

March 19, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6334 Cedar Lane

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Silvers Bakery

17. Father's Name (First, Middle, Last)

William Summers

18. Mother's Name (First, Middle, Maiden Surname)

Ellen

19a. Informant's Name/Relationship (Type, Print)

Mary Bond

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6587 Quiet Hours Apt. T1 Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

2/18/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss Funeral Home

3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bruce M. Conger MD Internist

29c. License number

D37013

29d. Date signed (Month, Day, Year)

Feb 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce M. Conger MD #210 11055 Little Patuxent Pkwy, Columbia, MD 21044

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John R. Bond

State Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1967

1968

1969

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04410

| | | | | | | | |
|-------------------------------------|---|---------------------------------|---|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GEORGE BUNGER JR. | | | 2. Date of Death
Month FEB Day 13 Year 1997 | | 3. Time of Death
4:55 PM | |
| | 4a. Facility Name (If not institution, give street and number)
1905 JACKSON RD. | | | 4b. City, Town, or Location of Death
DUNDALK | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
217-24-5147 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
68 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
JUNE 12, 1928 |
| | 9. Birthplace (State or Foreign Country)
MD. | | | | | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | | | |
| | 10a. State
MD. | 10b. County
BALTIMORE | 10c. City, Town or Location
DUNDALK | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1905 JACKSON RD. | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 6TH College (1-4 or 5+) | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
JANITOR | | 16b. Kind of Business/Industry
HOSPITAL | | |
| | 17. Father's Name (First, Middle, Last)
GEORGE BUNGER SR. | | | 18. Mother's Name (First, Middle, Maiden Surname)
CATHERINE Phillips | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
CLARA DURHAM | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 HASPERT RD APT E. PERRY HALL MD 21236 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH | | Date
2/18 | 20c. Location - City or Town, State
BALTO, MD. | |
| | 21. Signature of Funeral Service Licensee
Anthony C. Connelly | | | 22. Name and Address of Facility
CONNELLY FUNERAL HOME OF DUNDALK
7110 SOLLERS POINT RD BALTO, MD 21222 | | | |
| | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Gastro-intestinal Bleeding
Due to (or as a consequence of):
b. Gunshot - Throat
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
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h.
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

State Registrar

97 04411

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
Baby Girl "A" Campbell | | | | 2. DATE OF DEATH
MONTH January DAY 31 YEAR 1997 | | 3. TIME OF DEATH
11 57 A M | |
| 4. SOCIAL SECURITY NUMBER
N/A | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
YRS. MONTHS DAYS HOURS MIN.
20 | | 7. DATE OF BIRTH
(Month, Day, Year)
January 31, 1997 | |
| 9a. FACILITY NAME (If not institution, give street and number)
Greater Baltimore Medical Center | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Towson Maryland | | 9c. COUNTY OF DEATH
Baltimore | |
| 10a. STATE
Maryland | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
3621 Gelston Drive | | | | 10f. ZIP CODE
21229 | | 10g. CITIZEN OF WHAT COUNTRY? | |
| 11. MARITAL STATUS
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: unknown | | 14. RACE — American Indian, Black, White, etc.
Specify: Black | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last)
Steven Alther Campbell | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Bridgit E Bowers | | | |
| 19a. INFORMANT'S NAME (Type/Print)
G.B.M.C. PATHOLOGIST | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6701 NORTH CHARLES ST. TOWSON, MD. 21204 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
GREEN MOUNT CEMETERY 2/12/97 BALTO., MD. | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
William R. Puccio III | | | | 22. NAME AND ADDRESS OF FACILITY
HENRY W. SANKINS & SONS CO.
4705 YORK RD. BALTO., MD. 21212 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Immaturity Campbell

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. HAS A Fetal
c. Twin
d. | | | | | | | Approximate Interval Between Onset and Death
20 min |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I:

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| 29a. CERTIFIER
(Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Pathak Head, Div of NB Med. | | | | 29c. LICENSE NUMBER
D22244 | | 29d. DATE SIGNED (Month, Day, Year)
February 7, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ambadas Pathak - GRMC 6701 N. Charles Street: Baltimore MD 21204 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 18 1997 | | 32. REGISTRAR'S SIGNATURE
G. Davidson-Rendell | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

JA

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04412

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frankie Mase Corathers

2. Date of Death
Month Day Year

February 17, 1997

3. Time of Death

10:12 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Manor Care - Rossville Nursing Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

213-36-1389

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Aug. 29, 1905 West Virginia

9. Birthplace (State or Foreign
Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Rossville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7911 Elmhurst Avenue

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever In U.S.
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Shiflet

18. Mother's Name (First, Middle, Maiden Surname)

Rosa D. Stutler

19a. Informant's Name/Relationship (Type, Print)

Sharon Lubbehusen (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7911 Elmhurst Ave. Rossville, Md. 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parkwood Cemetery

Date

2/20/1997

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdzinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Sepsis

e.

Due to (or as a consequence of):

Multiple gangrenous wounds

b.

Due to (or as a consequence of):

Severe Peripheral Vascular disease

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

2-3 weeks

7-8 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition, Bronchiectasis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

February 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MALIKA WASEEM. 100. N. BROADWAY. M.D. - 21231

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04413

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Joyce L. Conner | | | | 2. Date of Death
Month February Day 17 , Year 1997 | | 3. Time of Death
4:10 PM | |
| | 4a. Facility Name (If not institution, give street and number)
2227 Vailthorn Road | | | | 4b. City, Town, or Location of Death
Middle River | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
096-16-9186 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | 8. Date of Birth (Month, Day, Year)
Feb. 24, 1923 | |
| | 9. Birthplace (State or Foreign Country)
New York | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Middle River | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
2227 Vailthorn Road | | 10f. Zip Code
21220 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 Collage (1-4or 5+) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | | 16b. Kind of Business/Industry
Own Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Floyd Kilmer | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hattie Boughteu | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ricky Conner (SON) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1011 Middlesex Road Essex, Md. 21221 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gardens 2/21/1997 | | 20c. Location - City or Town, State
Baltimore Co., Md. | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | | | 22. Name and Address of Facility
Bruzdinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
Minutes | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):
d. _____ Due to (or as a consequence of): | | | | | | | |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- chronic abd. pain 2^o to colonie inertia | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
<i>[Signature]</i> M.D. | | | | 29c. License number
041680 | | 29d. Date signed (Month, Day, Year)
February 18, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
8100 HARFORD RD. BLT. MD. 21234 | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
<i>[Signature]</i> | | | |
| | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04414

Certificate of Death

Reg. No.

| | | | | | | | | | | | |
|--|---|--|---|---|--|---------------------------------|---------------------------------|---|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Oliver | | | | 2. Date of Death
Month February Day 17 Year 1997 | | | | 3. Time of Death
1:36 A. M. | | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rossville | | | | 4c. County of Death
Baltimore | | |
| Funeral
Director | 5. Social Security Number
212-30-4033 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
62 Yrs. | | If Under 1 Year
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| | 6. Date of Birth (Month, Day, Year)
Nov. 30, 1934 | | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
1560 Alconbury Rd. | | | | 10f. Zip Code
21221 | | | | 10g. Citizen of What Country?
U.S.A. | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Maintenance Supervisor | | | | 16b. Kind of Business/Industry
Baltimore City | | |
| | 17. Father's Name (First, Middle, Last)
Oliver J. Caple | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Clara Wideman | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Eva M. Caple (WIFE) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1560 Alconbury Rd. Essex, Md. 21221 | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery | | | | 20c. Location - City or Town, State
Baltimore Co., Md. | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bruzdinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Md. 21221 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

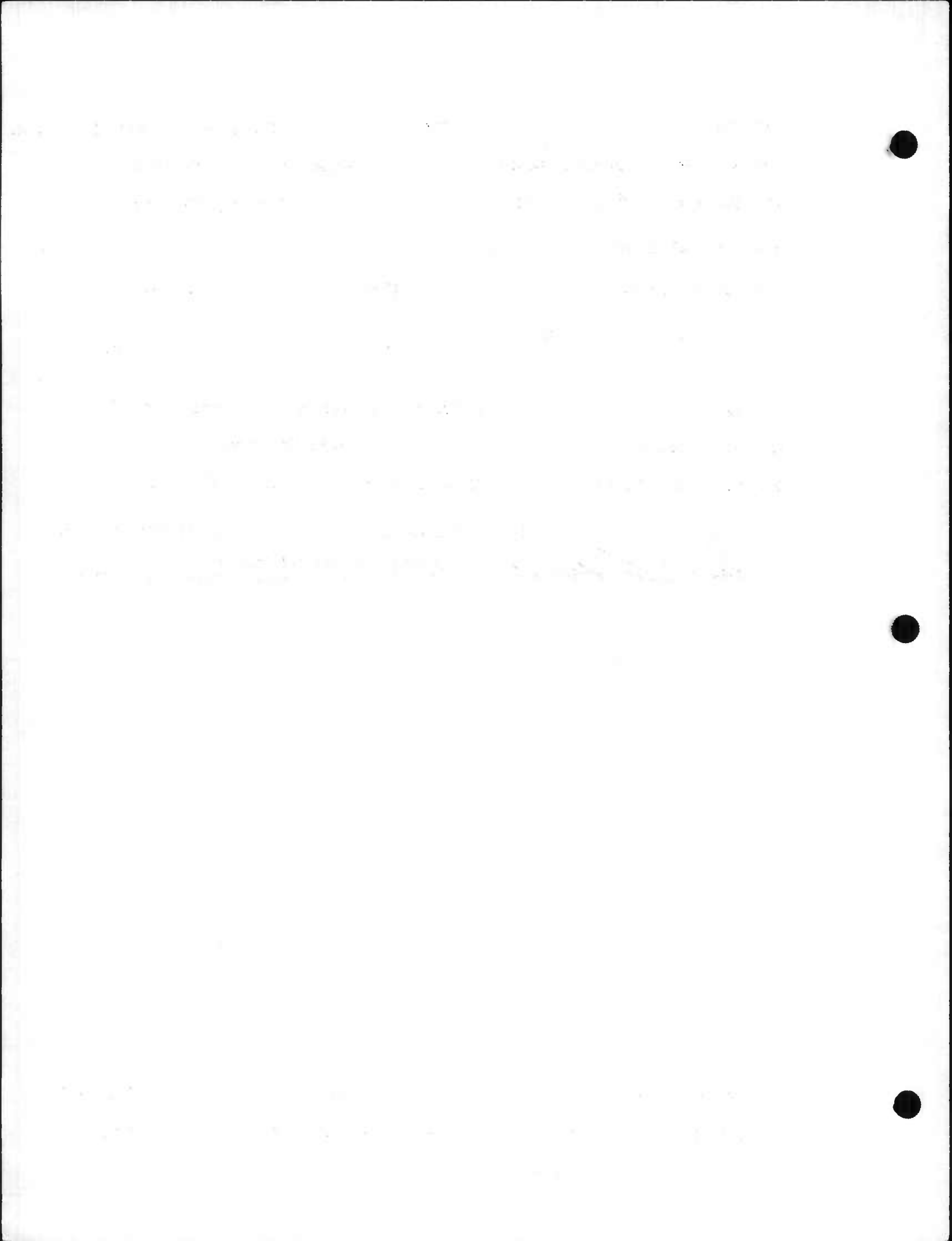
e. <i>Massive upper gastrointestinal bleed</i>
Due to (or as a consequence of):
f. <i>Esophageal varices</i>
Due to (or as a consequence of):
g. <i>Liver cirrhosis</i>
Due to (or as a consequence of):
h.
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
30' | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Chronic obstructive pulmonary disease</i> | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Homicide | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | | 29c. License number
0-18151 | | 29d. Date signed (Month, Day, Year)
February 18, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Chi-Shiang Chen, M.D. 98 N. Broadway #410 Balto., MD 21231 | | | | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04415

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>HELEN L. CHASE</u> | | | | 2. Date of Death
Month <u>FEB</u> Day <u>10</u> Year <u>1997</u> | | 3. Time of Death
<u>5:10 pm</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>WASHINGTON ADVENTIST HOSPITAL</u> | | | | 4b. City, Town, or Location of Death
<u>MONTGOMERY</u> | | 4c. County of Death
<u>MONTGOMERY</u> | |
| Funeral
Director | 5. Social Security Number
<u>577 05 4906</u> | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<u>88</u> Yrs. | | 8. Date of Birth (Month, Day, Year)
<u>OCT 21 1908</u> | |
| | 9. Birthplace (State or Foreign Country)
<u>WASH. D.C.</u> | | 10a. State
<u>D.C.</u> | | 10b. County
<u>WASHINGTON</u> | | 10c. City, Town or Location
<u>WASHINGTON</u> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
<u>1842 2nd STREET, N.W.</u> | | 10f. Zip Code
<u>20001</u> | | 10g. Citizen of What Country?
<u>USA</u> | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>BLACK</u> | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>FOOD SERVICE WORKER</u> | | 16b. Kind of Business/Industry
<u>PVT.</u> | | | |
| | 17. Father's Name (First, Middle, Last)
<u>CHARLES LOMAX</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>NOT STATED</u> | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
<u>THERESA E. CHASE/DAUGHTER</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>1842 2nd ST., N.W. WASH.D.C. 20001</u> | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>NO. VA. CREMATORY FEB 12 1997 ARLINGTON, VA.</u> | | 20c. Location - City or Town, State | | 20d. Date | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
<u>[Signature]</u> | | | | 22. Name and Address of Facility
<u>WATSON F. H. INC.</u>
<u>3435 14th ST., N.W. 20010</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<u>Bacteroides fragilis sepsis</u>
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
<u>3 days</u> | | | |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>Renal failure</u>
<u>Diabetes Mellitus</u> | | | | 23c. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
<u>Norton Elson MD</u> | | 29c. License number
<u>D 20362</u> | | 29d. Date signed (Month, Day, Year)
<u>February 11, 1997</u> | |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Norton Elson, 6525 Belcrest Rd Hyattsville MD 20782</u> | | | | 31. Date signed (Month, Day, Year)
<u>FEB 18 1997</u> | | | |
| | 32. Registrar's Signature
<u>[Signature]</u> | | | | 33. Registrar's Title
<u>Registrar</u> | | | |

97 04416

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
MARGARET ADELE CARDINI | | | | 2. DATE OF DEATH
MONTH 2 DAY 14 YEAR 97 | | 3. TIME OF DEATH
6:35A M | | | |
| 4. SOCIAL SECURITY NUMBER
213-10-5762 | | 5. SEX
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
76 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
Sept 14, 1920 | | 8. BIRTHPLACE (State or Foreign Country)
Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number)
Good Samaritan Nursing Cntr. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Baltimore | | | 9c. COUNTY OF DEATH
N/A | | |
| 10a. STATE
Maryland | | 10b. COUNTY
N/A | | 10c. CITY, TOWN OR LOCATION
Baltimore | | | 10d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 10e. STREET AND NUMBER
4514 Keswick Road | | | | 10f. ZIP CODE
21210 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A | | | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | | 14. RACE — American Indian, Black, White, etc.
Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
Salesperson | | | 16b. KIND OF BUSINESS/INDUSTRY
Brager-Gutman Store | | |
| 17. FATHER'S NAME (First, Middle, Last)
Chester Schauck | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
Esther Meyers | | | | | |
| 19a. INFORMANT'S NAME (Type/Print)
Sharon A. Warner (Daughter) | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
108 Charmuth Road, Timonium, Md. 21093 | | | | | |
| 20a. METHOD OF DISPOSITION
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
Lorraine Park Cemetery | | DATE
2/17 | | 20c. LOCATION — City or Town, State
Baltimore, Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
A. Alan Seitz, Jr. | | | | 22. NAME AND ADDRESS OF FACILITY
A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Maryland 21212 | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. EXACERBATION OF COPD
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. POSSIBLE PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):

c. LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):

d. LUNG CANCER | | | | | | | | Approximate Interval Between Onset and Death
1 day | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
LUNG CANCER | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 28d. DESCRIBE HOW INJURY OCCURRED | |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
Carl Sperling | | | | 29c. LICENSE NUMBER
D28987 | | 29d. DATE SIGNED (Month, Day, Year)
2-14-97 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CARL SPERLING, MD. 5601 LOCH RAVEN BLVD BALTO. MD 21239 | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 18 1997 | | 32. REGISTRAR'S SIGNATURE
A. Davidson-Hendell | | | | | | | |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04417

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)
Birdie L. Crist | | | | 2. Date of Death
Month Day Year
02 13 1997 | | 3. Time of Death
10:50 a.m. | |
| 4a. Facility Name (If not institution, give street and number)
Baptist Home | | | | 4b. City, Town, or Location of Death
Owings Mills | | 4c. County of Death
Baltimore | |
| 5. Social Security Number
216-10-4493 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 Yrs. | | 8. Date of Birth (Month, Day, Year)
10/27/1903 | |
| 9. Birthplace (State or Foreign Country)
VA | | 10a. State
Md | | 10b. County
Carroll | | 10c. City, Town or Location
Mt. Airy | |
| 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
17316 Old Frederick Road | | 10f. Zip Code
21771 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Collage (1-4 or 5+)
11 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Hairdresser | | 16b. Kind of Business/Industry
Beauty | | | |
| 17. Father's Name (First, Middle, Last)
Claude Burruss | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Alice Sizer | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Louis Weinkam/Attorney | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1002 Frederick Road/Catonsville, Md 21228 | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Cemetery | | 20c. Location - City or Town, State
2/17 Baltimore, Md. | | | |
| 21. Signature of Funeral Service Licensee
Phyllis Stouts | | | | 22. Name and Address of Facility
Sterling Ashton Funeral Home, Inc
736 Edmondson Avenue Balto, Md 21228 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. <u>urosepsis</u>
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
N/A | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| 29b. Signature and title of certifier
Ted Hawk | | | | 29c. License number
D41104 | | 29d. Date signed (Month, Day, Year)
2.14.97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ted Hawk 7825 York Rd Towson MD 21204. | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | | | | |
| 32. Registrar's Signature
Gina Davidson-Rendell | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be attached to the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04418

| | | | | | | | | |
|---|---|----------------------------|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Beatrice E. Cook | | | | 2. Date of Death
Month February Day 15 Year 97 | | 3. Time of Death
12:30p.m. | |
| | 4a. Facility Name (If not institution, give street and number)
2711 Fenwick Ave. | | | | 4b. City, Town, or Location of Death
Balto. | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
213-30-8555 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
June 6, 1932 | 9. Birthplace (State or Foreign Country)
Md. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | 10b. County
N/A. | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
2711 Fenwick Ave. | | | | 10f. Zip Code
21218 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 Collega (1-4 or 5+) | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | 16b. Kind of Business/Industry
Home | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Walter Birins | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Hill | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Steve Cook / Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2711 Fenwick Ave. Balto., Md. 21218 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. | | 20c. Location - City or Town, State
2-21-97 Balto., Md. | | | |
| | 21. Signature of Funeral Service Licensee
James A. Morton | | | | 22. Name and Address of Facility
James A. Morton & Sons
1701 Laurens St. Balto., Md. 21217 | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Small Cell lung carcinoma
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hypertension
Due to (or as a consequence of):

c. Congestive heart failure
Due to (or as a consequence of):

d. | | | | | | | Approximate Interval Between Onset and Death
7 months |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
Asthma | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
M
28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| State
Registrar | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
Ken Turtul | | | | 29c. License number
D26923 | | 29d. Date signed (Month, Day, Year)
2/17/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K. TRET-MINS MID. 709 E. LOMBARD ST. 21202 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
Davidson-Rendelle | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04419

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Louis L. Clabaugh</i> | | | | 2. Date of Death
Month <i>Feb</i> Day <i>16</i> Year <i>1997</i> | | 3. Time of Death
<i>1709</i> | |
| | 4a. Facility Name (If not institution, give street and number)
<i>North Arundel Hospital</i> | | | | 4b. City, Town, or Location of Death
<i>Glen Burnie</i> | | 4c. County of Death
<i>AA</i> | |
| Funeral
Director | 5. Social Security Number
<i>213 30 0786</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (in yrs. last birthday)
<i>64</i> Yrs. | | 8. Date of Birth (Month, Day, Year)
<i>Sept. 13, 1932</i> | |
| | 9. Birthplace (State or Foreign Country)
<i>Maryland</i> | | 10a. State
<i>Maryland</i> | | 10b. County
<i>Anne Arundel</i> | | 10c. City, Town or Location
<i>Linthicum</i> | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
<i>6310 Homewood Road</i> | | 10f. Zip Code
<i>21090</i> | | 10g. Citizen of What Country?
<i>U.S.</i> | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>Korean Conflict</i> | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | |
| | 15. Decedent's Education (Specify only highest grade completed)
<i>Elementary/Secondary (0-12)</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Transportation Manager</i> | | 16b. Kind of Business/Industry
<i>W.R. Grace - Chemical</i> | | | |
| | 17. Father's Name (First, Middle, Last)
<i>Louis Clabaugh</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Christine Schwartzkoff</i> | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>Cheryl Clabaugh / daughter</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>415 Nawakwa Road Biglerville, Pennsylvania 17307</i> | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Glen Haven Mem. Park</i> | | 20c. Location - City or Town, State
<i>2/19/97 Glen Burnie, Maryland</i> | | | |
| | 21. Signature of Funeral Service Licensee
<i>Donna M. Zmijewski</i> | | 22. Name and Address of Facility
<i>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</i> | | | | | |
| | 23a. Pert I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
<i>a. Acute Cardiac Arrhythmia</i>
Due to (or as a consequence of):
<i>b. Arteriosclerotic Heart Disease</i>
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>c.</i>
Due to (or as a consequence of):
<i>d.</i>
Due to (or as a consequence of): | | | | | | Approximate Interval Between Onset and Death
<i>minutes</i> | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
<i>William R. Jones Deputy</i> | | 29c. License number
<i>D 06054</i> | | 29d. Date signed (Month, Day, Year)
<i>2/17/97</i> | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>William P. Jones, MD 695 America 21035</i> | | | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
<i>FEB 18 1997</i> | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.



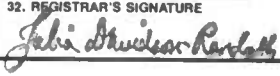
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 04420

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
ABRAHAM CLAPMAN | | | | 2. DATE OF DEATH
FEBRUARY 13, 1997 | | 3. TIME OF DEATH
2:05 PM | |
| 4. SOCIAL SECURITY NUMBER
130-10-8232 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
84 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
DEC. 17, 1912 | |
| 9a. FACILITY NAME (If not institution, give street and number)
HEBREW HOME OF GREATER WASH. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
ROCKVILLE | | 9c. COUNTY OF DEATH
MONTGOMERY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE
MD | | 10b. COUNTY
BALTIMORE | | 10c. CITY, TOWN OR LOCATION
BALTIMORE | | 10d. INSIDE CITY LIMITS?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7203 ROCKLAND HILLS DRIVE | | | | 10f. ZIP CODE
21209 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
CARPENTER | | 16b. KIND OF BUSINESS/INDUSTRY
HOME IMPROVEMENT | |
| 17. FATHER'S NAME (First, Middle, Last)
BARNETT CLAPMAN | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MIRIAM FLIESCHER | | | |
| 19a. INFORMANT'S NAME (Type/Print)
THERESA CLAPMAN / WIFE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7203 ROCKLAND HILLS DRIVE BALTIMORE, MD 21209 | | | |
| 20a. METHOD OF DISPOSITION
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)
UNITED HEBREW | | DATE
2/16, 1997 | | 20c. LOCATION — City or Town, State
STATEN ISLAND, NY | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
 | | | | 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC.
8900 Reisterstown Road Pikesville, MD 21208 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONITIS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| b. CEREBROVASCULAR DISEASE | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| c. INSULIN DEPENDENT DIABETES MELLITUS | | | | | | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| d. | | | | | | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | |
| | | 28d. DESCRIBE HOW INJURY OCCURRED | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |
| 29a. CERTIFIER (Check only one)
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
 | | | | 29c. LICENSE NUMBER
D 05885 | | 29d. DATE SIGNED (Month, Day, Year)
FEB 13, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE, MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 18 1997 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04421

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

VIRGINIA MOOREFIELD CLEARY

2. Date of Death

Month Day Year
FEB 14, 1997

3. Time of Death

8:18 PM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-03-2959

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
December 17, 1911

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6630 Loch Hill Road

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Retail Department Store

17. Father's Name (First, Middle, Last)

James Moorefield

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Ayers

19a. Informant's Name/Relationship (Type, Print)

Richard B. Cleary Jr

Husband 6630 Loch Hill Road Baltimore, Maryland 21239

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

2/18/97

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Dennis Stephen Kenaker

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

1 DAY

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis Stephen Kenaker M.D.

29c. License number

P10582

29d. Date signed (Month, Day, Year)

FEB 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANN MECHERIKUNNEL, 5601, LOCH RAVEN BLVD, BALTIMORE, MD-21239

31. Date filed (Month, Day, Year)

FEB 18 1997

Julia B. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04422

Certificate of Death

Reg. No.

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
FRANCES MITCHELL CHENOWETH | | 2. Date of Death
Month Day Year
FEBRUARY 14 1997 | | 3. Time of Death
9:50P.M. |
| | 4a. Facility Name (If not institution, give street and number)
SAINT JOSEPH MEDICAL CENTER | | 4b. City, Town, or Location of Death
TOWSON, MARYLAND | | 4c. County of Death
BALTIMORE |
| Funeral
Director | 5. Social Security Number
216-07-2455 | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)
80 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Nov. 20, 1916 | | 9. Birthplace (State or Foreign Country)
Balto. Md. | | |
| To Be Completed by Funeral Director | 10a. State
Md. | | 10b. County
Balto. Co. | | 10c. City, Town or Location
Towson |
| | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 10e. Street and Number
1200 Windy Gate Road | | 10f. Zip Code
21286 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2 | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Office Manager | | 16b. Kind of Business/Industry
Coal Business |
| | 17. Father's Name (First, Middle, Last)
Robert J. Mitchell | | 18. Mother's Name (First, Middle, Maiden Surname)
Leona Brooks | | |
| | 19a. Informant's Name/Relationship (Type, Print)
David R. Chenoweth - Son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 Bandon Ct. #302, Timonium, Md. 21093 | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery | | 20c. Location - City or Town, State
2/17/97 Pikesville, Md. |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
Mitchell-Wiedefeld Home, Inc.
6500 York Rd. Balto. Md. 21212 | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | |
| Approximate Interval Between Onset and Death
10 DAYS | | | | | |
| Physician
/Medical
Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEVERE AORTIC INSUFFICIENCY
CONGESTIVE HEART FAILURE | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| | | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
M | | 28b. Time of Injury
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D41410 | | 29d. Date signed (Month, Day, Year)
February 14, 1997 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOGINDER P. MEHTA, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

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41

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04423

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BABY GIRL TATYANA D. DANCY (WILLIAMS)

2. Date of Death

Month Day Year
FEBRUARY 14, 1997

3. Time of Death

08:38PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

NA

Funeral
Director

5. Social Security Number

NA

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

15

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 30, 1997

9. Birthplace (State or Foreign Country)

md

Usual Residence of Decedent

10a. State

md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3742 Columbus Drive

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

NA

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

NA

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

Anthony Dancy

18. Mother's Name (First, Middle, Maiden Surname)

Tilia Williams

19a. Informant's Name Relationship (Type, Print)

Tilia Dancy-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3742 Columbus Dr. Balto. Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

King Memorial Park

Date

20c. Location - City or Town, State

Randallstown, md

21. Signature of Funeral Service Licensee

Blayne B. Harris

22. Name and Address of Facility

March Funeral Home-West
4300 Wabash Ave. Balto. md. 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. HEART FAILURE

Due to (or as a consequence of):

b. IN-UTERO ASPHYXIA

Due to (or as a consequence of):

c. MATERNAL DIABETES

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

14 days

16 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPATIC FAILURE

RENAL FAILURE

PORTAL VEIN THROMBOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. Alpan MD

29c. License number

DH2096

29d. Date signed (Month, Day, Year)

FEBRUARY 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. ALPAN, 600 N. WOLFE ST., BALTIMORE, MD 21205

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

$\frac{1}{2} \log \frac{1}{2}$
 $\frac{1}{2} \log \frac{1}{2}$

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04424

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE DIGGS

2. Date of Death
Month Day Year

FEBRUARY 06, 1997

3. Time of Death

07:15 PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578-56-2486

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

3-11-1941

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

RIVERDALE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6616 GREENVALE PARKWAY

10f. Zip Code

20737

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

STEAM ENGINEER

16b. Kind of Business/Industry

HOWARD UNIVERSITY

17. Father's Name (First, Middle, Last)

GEORGE E. DIGGS SR.

18. Mother's Name (First, Middle, Maiden Surname)

GRACE C. GRAY

19a. Informant's Name/Relationship (Type, Print)

ARLENE M. DIGGS WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6616 GREENVALE PKWY, RIVERDALE, MD 20737

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

FORT LINCOLN CEMETERY

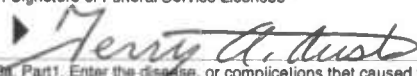
Date

2-14-97

20c. Location - City or Town, State

BRENTWOOD, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

AUSTIN ROYSTER FUNERAL HOME

3821 14TH ST NW WASHINGTON, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

X AND RENAL FAILURE, STATUS POST KIDNEY TRANSPLANT

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

DEPUTY MEDICAL EXAMINER
D33954

29d. Date signed (Month, Day, Year)

FEBRUARY 07, 1997

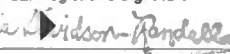
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARIO F. GOLUB JR M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04425

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LUCILLE M DUVALL

2. Date of Death

FEBRUARY 16, 1997

3. Time of Death

9:55AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-20-0217

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT 2 1915

9. Birthplace (State or Foreign Country)

RHODE ISLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

HALTHORPE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4413 MAPLE AVENUE

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5 +

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

VICE PRINCIPAL

16b. Kind of Business/Industry

BALTIMORE COUNTY
SCHOOLS

17. Father's Name (First, Middle, Last)

ALPHONSUS MILLER

18. Mother's Name (First, Middle, Maiden Surname)

IDA DENT

19a. Informant's Name/Relationship (Type, Print)

DIANE D. LLOYD, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 FAIRFIELD DR., CATONSVILLE, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Data

2-17

20c. Location - City or Town, State

BELTSVILLE, MD

21. Signature of Funeral Service Licensee

Phillips

22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.
736 EDMONDSON AVE., BALT., MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. atherosclerotic coronary vessel disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. respiratory distress

Due to (or as a consequence of):

1 hour

c. essential thrombocythosis

Due to (or as a consequence of):

1 year

d. hypertension

20 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 8 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D050907

29d. Date signed (Month, Day, Year)

February 16, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

900 South Caton Avenue Baltimore, Maryland

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04426

Certificate of Death

Reg. No.

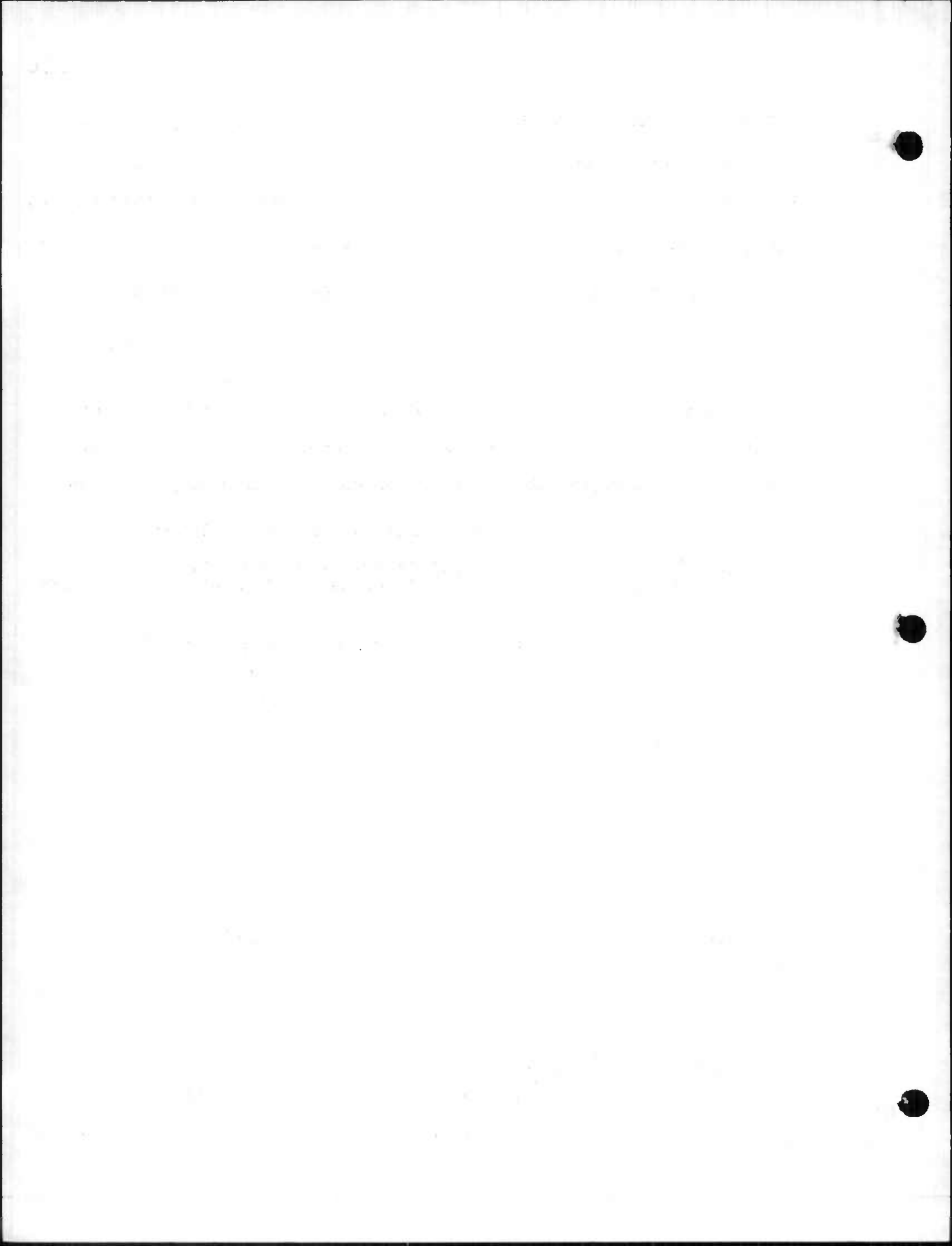
| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
GLADYS MARIE DANIEL | | | | 2. Date of Death
Month February Day 18 , Year 1997 | | 3. Time of Death
12:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
940 Beaver Bank Circle | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
251 10 0268 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
80 Yrs. | | 8. Date of Birth (Month, Day, Year)
Oct. 3, 1916 | |
| | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Funeral Director | 10e. Street and Number
940 Beaver Bank Circle | | | | 10f. Zip Code
21286 | | 10g. Citizen of What Country?
United States | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) Unknown | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Regional Manager | | 16b. Kind of Business/Industry
In Home sales Co | | | |
| | 17. Father's Name (First, Middle, Last)
Robert Nettles | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Mamie (Unknown) | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Bobbie Thomas Scruggs/daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
940 Beaver Bank Cir., Baltimore, MD 21286 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | 20c. Location - City or Town, State
Baltimore, MD | | 20d. Date
2/18/97 | |
| | 21. Signature of Funeral Service Licensee
<i>Stephen D. Lohrmann</i> | | | | 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. chronic obstructive pulmonary Disease years
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| | 29b. Signature and title of certifier
<i>Fredric S. Sirkis MD</i> | | | | 29c. License number
D22645 | | 29d. Date signed (Month, Day, Year)
2/18/97 | |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FREDRIC S. SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
<i>William R. Riddell</i> | | | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04427

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|--|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELIZABETH DEAL | | | | 2. Date of Death
Month Day Year
FEBRUARY 17th 1997 | | 3. Time of Death
14:55 | |
| | 4a. Facility Name (If not institution, give street and number)
Augsburg Lutheran Home | | | | 4b. City, Town, or Location of Death
Woodlawn | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
189-12-8792 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
72 Yrs. | | 8. Date of Birth (Month, Day, Year)
May 29, 1924 | |
| | 9. Birthplace (State or Foreign Country)
Pennsylvania | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Catonsville | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
2 B McIntosh Court | | 10f. Zip Code
21228 | |
| | 10g. Citizen of What Country?
U.S.A. | | | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | | | 16b. Kind of Business/Industry
Own Home | | 17. Father's Name (First, Middle, Last)
George Jasper Campbell | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth May Harritty | | | | 19a. Informant's Name/Relationship (Type, Print)
Forest C. Deal, Sr. | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 B McIntosh Court Catonsville, Maryland 21228 | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Washington Park Cemetery | | 20c. Location - City or Town, State
Indianapolis, Indiana | |
| | 21. Signature of Funeral Service Licensee
R. Craig Witzke | | | | 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
END STAGE HYPERTENSIVE CARDIOMYOPATHY | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA
Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | |
| | 28a. Date of Injury (Month, Day Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Deborah I. Pierce DO | | 29c. License number
D45931 | |
| | 29d. Date signed (Month, Day, Year)
FEBRUARY 18, 1997 | | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DEBORAH I. PIERCE 7220 PARK HEIGHTS AVENUE BALTIMORE, MD | | 31. Data filed (Month, Day, Year)
FEB 18 1997 | |
| | 32. Registrar's Signature
Julia Davidson-Rendell | | | | 33. State Registrar | | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | |
| | 35. Medical Certification: To Be Completed by Physician/Medical Examiner | | | | 36. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | | 37. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04428

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LEANDER DAILEY

2. Date of Death

Month Day Year
Feb 12 1997

3. Time of Death

11:00 A.M.

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

065-09-3514

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 8, 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

717 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insurance Executive

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

David Dailey

18. Mother's Name (First, Middle, Maiden Surname)

Louise Siegel

19a. Informant's Name/Relationship (Type, Print)

Joan Michas (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

53 Alpine Trail Sparta, New Jersey 07871

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John's Cemetery

Date

February

20c. Location - City or Town, State

Ellicott City, Maryland

21. Signature of Funeral Service Licensee

Robert George Bishara

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Bleed

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Basal Cell Carcinoma Right ear, atrial

Fibrillation, Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert George Bishara MD

29c. License number

P.O. 9885

29d. Date signed (Month, Day, Year)

Feb, 12, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Hartham Bishara St Agnes Hospital 900 Caton Ave. Baltimore MD

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John H. Bond

21228

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04429

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD A. FULLER

2. Date of Death

Month Day Year
Feb 15 1997

3. Time of Death

4:25am

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

097-22-0238

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG 13, 1930

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5901 Sunset Avenue

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Civilian Employee /
Radio Transmitter Operator

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Harold Ives Fuller

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle Kelder

19a. Informant's Name/Relationship (Type, Print)

Mary Anne Fuller / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5901 Sunset Avenue Baltimore, MD 21207

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 02/15/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Md., Inc.
299 Frederick Road Balto., MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Lung cancer

Approximate Interval Between Onset and Death

11 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

PO 9144

29d. Date signed (Month, Day, Year)

Feb 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA B. NIKULSKA, ST. AGNES HOSP, 900 CATON AVE, BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

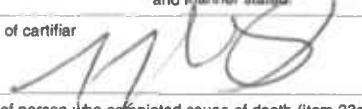
Certificate of Death

Reg. No.

97 04430

| | | | | | | | | |
|--|--|---|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ELLEANORE S. FRY | | | | 2. Date of Death
Month Day Year
February 11 1997 | | 3. Time of Death
8:20 a.m. | |
| | 4a. Facility Name (If not institution, give street and number)
Calvert County Nursing Center, Inc. | | | | 4b. City, Town, or Location of Death
Prince Frederick | | 4c. County of Death
Calvert | |
| Funeral
Director | 5. Social Security Number
441-09-2293 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
86 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
8-24-1910 | 9. Birthplace (State or Foreign Country)
OAKLAHOMA | |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by
Funeral Director | 10a. State
MD | 10b. County
PRINCE GEORGES | 10c. City, Town or Location
COTTAGE CITY | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
4142 BUNKER HILL ROAD | | | 10f. Zip Code
20722 | | 10g. Citizen of What Country?
USA | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4 YRS | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
BEAUTICIAN | | 16b. Kind of Business/Industry
SELF-EMPLOYED | | | |
| | 17. Father's Name (First, Middle, Last)
WINIFIELD SCOTT | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ETTA FLORENCE | | | |
| To Be Completed by
Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
BILLIE JO BUCKMASTER DAUGHTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5040 SANDY POINT ROAD, PRINCE FREDERICK, MD 20678 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GEORGETOWN MED. SCHOOL | | 20c. Location - City or Town, State
WASHINGTON, D.C. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH ST N.W. WASH. DC 20011 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
Acute Myocardial Infarction
Due to (or as a consequence of):
Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Atrial Fibrillation; Organic Brain Syndrome | | | | | | | Approximate Interval Between Onset and Death |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation; Organic Brain Syndrome | | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | 29c. License number
033123 | 29d. Date signed (Month, Day, Year)
2-11-97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JONATHAN LOWENTHAL, M.D. 120 HOSPITAL RD. SUITE 200 PRINCE FREDERICK, MD 20678 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital: Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

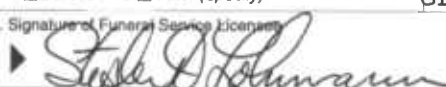
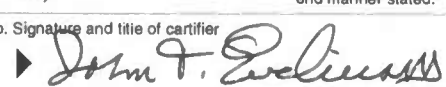
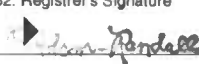
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04431

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Herbert Frank | | 2. Date of Death
Month February Day 12 Year 1997 | | 3. Time of Death
8:25PM |
| | 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview Medical Center | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a |
| Funeral
Director | 5. Social Security Number
153 10 9952 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
May 8, 1914 | | 9. Birthplace (State or Foreign Country)
New Jersey | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
Harford |
| | 10c. City, Town or Location
Abingdon | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
3826 Philadelphia Rd. | | 10f. Zip Code
21009 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 | | |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Structural Engineer | | 16b. Kind of Business/Industry
Steel Construction | | |
| | 17. Father's Name (First, Middle, Last)
(Unknown) | | 18. Mother's Name (First, Middle, Maiden Surname)
(Unknown) | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Edith Frank / wife | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3826 Philadelphia Rd., Abingdon, MD 21009 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | 20c. Location - City or Town, State
Baltimore MD |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286 | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)
e. DEMENTIA | | | | | YEARS |
| Due to (or as a consequence of): | | | | | |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | |
| Due to (or as a consequence of): | | | | | |
| Due to (or as a consequence of): | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
N/A | | 28b. Time of Injury
N/A M | |
| 28c. Injury at Work?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred
N/A | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
N/A | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)
N/A | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D34952 | | 29d. Date signed (Month, Day, Year)
2/13/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
5444 BELAIR ROAD BALTIMORE MARYLAND 21206 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04432

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Roy Clifford Fisher

2. Date of Death

February 14, 1997

3. Time of Death

10:20 AM

4e. Facility Name (If not institution, give street and number)

534 Southern Ave.

4b. City, Town, or Location of Death

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

219-382202

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-15-39

9. Birthplace (State or Foreign Country)

BALT. MDC

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

534 Southern Ave.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Anchor Fence

17. Father's Name (First, Middle, Last)

John A. Fisher

18. Mother's Name (First, Middle, Maiden Surname)

EVA Vogel

19a. Informant's Name/Relationship (Type, Print)

John A. Fisher Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

534 Southern Ave. Balt. Md.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

SACRED HEART OF JESUS

Date

2-17-97

20c. Location - City or Town, State

DUNOAK

21. Signature of Funeral Service Licensee

Patrick R. Perry

22. Name and Address of Facility

Charles S. Zeiler Son Inc. 6224 Eastern Ave. Balt. Md.

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ARTERIOsclerotic CARDIOVASCULAR Disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Years

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Williamson M.D.

29c. License number

D11171

29d. Date signed (Month, Day, Year)

February 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. P. Williamson 405 Frederick Ave CATONSVILLE 21228

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Davidson Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04433

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CORA LEE GARLAND

2. Date of Death
Month Day Year

February 13, 1997

3. Time of Death

8:30 PM

4e. Facility Name (If not institution, give street and number)

River View Nursing Center

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

218-32-5904

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Oct. 6, 1905

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13 Mecca Lane

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Grower

16b. Kind of Business/Industry

Florist

17. Father's Name (First, Middle, Last)

Richard Pierce

18. Mother's Name (First, Middle, Maiden Surname)

Molly White

19a. Informant's Name/Relationship (Type, Print)

Clay Garland (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1903 Haselmere Road Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens 2/17/1997

Date

20c. Location - City or Town, State

Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Coronary Vascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid Arthritis

Hypertension

Osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D19667

29d. Date signed (Month, Day, Year)

2/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Schwartz M.D. 606 Hammonds Lane Baltimore, Maryland 21225

State
Registrar

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04434

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|--|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
BABY GIRL GARNER | | | | 2. Date of Death
Month Day Year
FEBRUARY 12, 1997 | | 3. Time of Death
11:30 A | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
N/A | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
Yrs. 5 | | 8. Date of Birth (Month, Day, Year)
02/07/97 | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
Sparks | |
| Usual Residence of Decedent | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
15721 Yeoho Road | | 10f. Zip Code
21152 | | |
| 10g. Citizen of What Country?
USA | | 11. Marital Status
<input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | |
| 14. Race - American Indian, Black, White, etc.
Specify: white | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) N/A College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
N/A | | 16b. Kind of Business/Industry
N/A | | |
| 17. Father's Name (First, Middle, Last)
Anthony V. Garner | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Dina M. Crofoot | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Anthony Garner/Father | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15721 Yeoho Road, Sparks, Md. 21152 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Date
2/13 | | 20c. Location - City or Town, State
Beltsville, Md. | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Sterling Ashton Funeral Home, Inc
736 Edmondson Ave. Balto, Md. 21228 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGENITAL HEART DISEASE (COMPLEX)
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. 5 days
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PERIVENTRICULAR LEUKOMALACIA (CYSTIC) | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
G. Alpan MD | | | | 29c. License number
DH2096 | | 29d. Date signed (Month, Day, Year)
FEBRUARY 12, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
G. ALPAN, 600 N. WOLFE ST., BALTIMORE, MD 21205 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
 | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1945-1946

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04435

| | | | | | | | | |
|---|--|---|--|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN C. GONCE, SR. | | | | 2. Date of Death
Month FEBRUARY , Day 13 , Year 1997 | | 3. Time of Death
1400 HRS | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | |
| Funeral
Director | 5. Social Security Number
218-22-9305 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 11, 1909 | |
| | Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
Tenn. | | 10. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10a. State
Md. | | 10b. County
Carroll | | 10c. City, Town or Location
Sykesville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 10e. Street and Number
150 Brass Eagle Court | | | | 10f. Zip Code
21784 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanic | | 16b. Kind of Business/Industry
Automobile | | |
| 17. Father's Name (First, Middle, Last)
Hisacaoh Gonce | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Martha Collins | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Margaret Jean Crum | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
150 Brass Eagle Ct. Sykesville, Md. 21784 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation Service | | Date
2/14/97 | | 20c. Location - City or Town, State
Hampstead, Md. | | |
| 21. Signature of Funeral Service Licensee
Harry W. Hight | | | | 22. Name and Address of Facility
Haight Funeral Home
P.O. Box 195 Sykesville, Md. 21784 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
PNEUMONIA
Due to (or as a consequence of):
URINARY TRACT INFECTION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
7 DAYS
7 DAYS | | | | | | | | |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA, CHRONIC OBSTRUCTIVE LUNG DISEASE | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
Thomas G. Hight MD | | | | 29c. License number
B4 4439125 | | 29d. Date signed (Month, Day, Year)
FEBRUARY 13, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS GEORGE NORTHWEST HOSPITAL CENTER | | | | 5701 OLD COURT ROAD
RANDALLSTOWN 21133 | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
John Davidson-Randall | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA

97 04436

DHMH 16 Rsv 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04437

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Herget

2. Date of Death
Month Day Year

February 17 1997

3. Time of Death

3:45 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

216-58-1867

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Aug. 18, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

939 Alricks Way

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jacob J. Heuermann

18. Mother's Name (First, Middle, Maiden Summa)

Margaret Seibert

19a. Informant's Name/Relationship (Type, Print)

Nellie Herget (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

605 Tampa Road Essex, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Cemetery

Date

2/20/1997

20c. Location - City or Town, State

Baltimore Co., Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or combination of diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Acute Myocardial Infarction 2 days

Due to (or as a consequence of):

b.

Atrial Fibrillation

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18326

29d. Date signed (Month, Day, Year)

2/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Noem Gauhae M.D. 404 Eastern Ave Balto MD 21221

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

e. [Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital/Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04438

Certificate of Death

Reg. No.

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
SHARLINE P. HARGROVE | | | | 2. Date of Death
Month Day Year
FEB. 12, 1997 | | 3. Time of Death
1415 PM | |
| | 4a. Facility Name (If not institution, give street and number)
1617 BALMORA COURT | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
DA | |
| Funeral
Director | 5. Social Security Number
212-56-6952 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
46 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 4, 1950 | |
| | 9. Birthplace (State or Foreign Country)
md | | 10. Usual Residence of Decedent
10a. State: md 10b. County: DA 10c. City, Town or Location: Baltimore | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | |
| To Be Completed by Funeral Director | 10e. Street and Number
1617 Balmora Court | | | | 10f. Zip Code
21217 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unknown College (14 or 5+): unknown | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Private Duty Nursing | | 16b. Kind of Business/Industry
Private Home | |
| | 17. Father's Name (First, Middle, Last)
Joseph Hargrove | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Doris Coleman | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Barbara Howie - Friend | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3609 Springdale Ave. Baltimore md 21216 | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park | | 20c. Location - City or Town, State
Randallstown, md | | | |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee
Glynn B. Harris | | | | 22. Name and Address of Facility
March Funeral Home - West
4300 Wabash Ave. Balto. md. 21215 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Chronic obstructive pulmonary disease
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | |
| State Registrar | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hepatitis B. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | |
| | 24a. Was an autopsy performed?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier
David R. Fowler | | | | 29c. License number
O.C.M.E | | 29d. Date signed (Month, Day, Year)
FEB. 13, 1997 | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David R. Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | | | | |
| | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04439

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Verna M. Hayes

2. Date of Death

Month

Day

Year

02

11

97

3. Time of Death

7:25pm

4a. Facility Name (If not institution, give street and number)

John Hopkins Bayview Medical Center 4440 Eastern

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

212-30-1569

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 15, 1934

9. Birthplace (State or Foreign Country)

Baltimore City, Md

Usual Residence of Decedent

10a. State

md

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2108 Boston Street Apt. 609

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical Accounting

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Frederick W. Schaub

18. Mother's Name (First, Middle, Maiden Surname)

Mathilda J. Vodicka

19a. Informant's Name/Relationship (Type, Print)

Frederick F. Schaub

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

951 F. Richmond Rd. Belair, Md. 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus

Date

2-14-97

20c. Location - City or Town, State

Baltimore City, Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Charles S. Zeiler and Son, INC.
6224 Eastern Avenue Balto. Md 21224

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebral Vascular accident
Due to (or as a consequence of):c. Ruptured (L) carotid artery
Due to (or as a consequence of):d. Carotid artery disease
Hypertension

6 days

10 days

6 years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Scleroderma

Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

97115

29d. Date signed (Month, Day, Year)

02/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice L. Wilkenfeld 4940 Eastern Ave Baltimore MD 21224

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04440

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HARRIETT L HOWARD

2. Date of Death

Month Day Year
FEB 13 1997

3. Time of Death

12:30A

4a. Facility Name (If not institution, give street and number)

Church Home HOspital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral
Director

5. Social Security Number

213-12-3495

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 6, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3208 Auchentoroly Terrace

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Balto City/Dept of Ed

17. Father's Name (First, Middle, Last)

Jacob R. Howard

18. Mother's Name (First, Middle, Maiden Surname)

Susie S. Matthews

19a. Informant's Name/Relationship (Type, Print)

sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Norma Laws

3208 Auchentoroly Terrace Baltimore, MD 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Auburn Cemetery

Date

Feb 17

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility Nutter Funeral Homes, Inc.

2501 Gwynns Falls Parkway
Baltimore, Maryland 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Adler

29c. License number

D 46893

29d. Date signed (Month, Day, Year)

Feb 13 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clarene Sarkodee-Adler Church Home and Hospital

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John A. Johnson

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To be completed by Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To be completed by the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04441

Certificate of Death

Reg. No.

| | | | | | |
|--|---|--|--|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Margaret T. HAYES | | 2. Date of Death
Month February Day 15 Year 1997 | | 3. Time of Death
5:07 PM |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | 4b. City, Town, or Location of Death
ROSSVILLE | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
153107424 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
76 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Dec 15, 1920 | | 9. Birthplace (State or Foreign Country)
PENNSYLVANIA | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10e. State
MD | | 10b. County
BALTIMORE |
| | 10c. City, Town or Location
ROSEDALE | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
1303 ROXBORO ROAD | | 10f. Zip Code
21237 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Merriad
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | |
| | 17. Father's Name (First, Middle, Last)
ANDREW SAUCHELLI | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNA MUSTO | | |
| | 19a. Informant's Name/Relationship (Type, Print)
GEORGE T. HAYES / SON | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1303 ROXBORO ROAD ROSEDALE, MARYLAND 21237 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH | | 20c. Location - City or Town, State
BALTIMORE, MARYLAND |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
CVACH/ROSEDALE FUNERAL HOME
1211 CHESACO AVE 21237 | | |
| Physician
/Medical
Examiner | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c. Urinary Infection
Due to (or as a consequence of):
d. | | | | Approximate Interval Between Onset and Death
24 Hours |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
 | | 29c. License number
D19864 | | 29d. Date signed (Month, Day, Year)
Feb 15, 1997 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gregory Sarsfield MD. 9000 Franklin Square Dr. Balto, Md. 21237 | | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

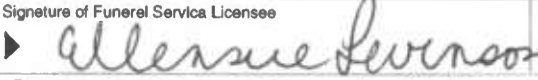
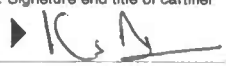

State
Registrar

DHMH 16 Rev 6/95

Certificate of Death

97 04442

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|--|---|--|--|---|---|-------------------------------------|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HELEN HOFFMAN | | | | 2. Date of Death
Month Day Year
FEBRUARY 14 97 | | 3. Time of Death
10:30 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
NORTHWEST HOSPITAL CENTER | | | | 4b. City, Town, or Location of Death
RANDALLSTOWN | | 4c. County of Death
BALTIMORE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
219-26-8078 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
58 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
APR 20, 1938 | 9. Birthplace (State or Foreign Country)
MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by
Funeral Director | 10a. State
MARYLAND | | 10b. County
BALTIMORE | | 10c. City, Town or Location
RANDALLSTOWN | | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
3921 INNERDALE COURT | | | | 10f. Zip Code
21133 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
NONE | | 16b. Kind of Business/Industry
NONE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
HENRY HOFFMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
LOTTIE JACOBS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by
Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
MR. SAUL JACOBS (COUSIN) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3907 SYBIL ROAD RANDALLSTOWN, MD 21133 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
BNAI ISRAEL | | 20c. Date
2-17-1997 | | 20d. Location - City or Town, State
BALTIMORE, MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. METASTATIC ADENOCARCINOMA</td> <td>Approximate Interval Between Onset and Death
MONTHS</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8"> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC ADENOCARCINOMA | | | | | | Approximate Interval Between Onset and Death
MONTHS | Due to (or as a consequence of): | | | | | | | b. Due to (or as a consequence of): | | | | | | | c. Due to (or as a consequence of): | | | | | | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | |
| Immediate Cause (Final disease or condition resulting in death) | a. METASTATIC ADENOCARCINOMA | | | | | | Approximate Interval Between Onset and Death
MONTHS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | c. Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SCHIZOPHRENIA | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 K.S. RAO, M.D. | | | | 29c. License number
D43462 | | 29d. Date signed (Month, Day, Year)
FEBRUARY 14 97 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K.S. RAO, M.D. NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

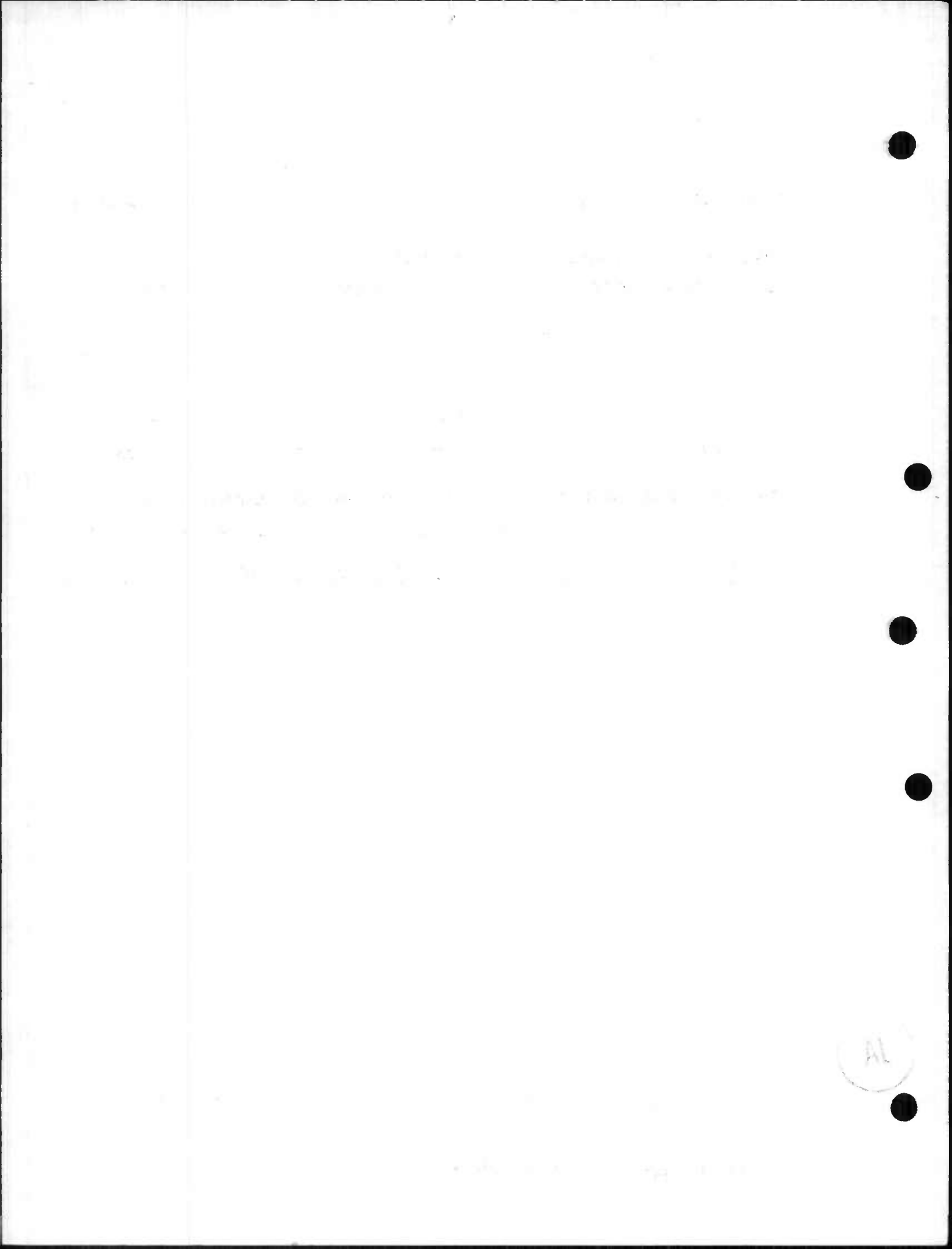
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Registrar of Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

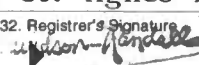
97 04443

| | | | | | | | | |
|---|--|---|---|--------------------------------------|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JOHN B. HOLLIDAY | | | | 2. Date of Death
Month Day Year
February 15, 1997 | | 3. Time of Death
8:50 AM | |
| | 4a. Facility Name (If not institution, give street and number)
ST. AGNES HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
190-18-5517 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
OCT. 5, 1905 | |
| | 9. Birthplace (State or Foreign Country)
MARYLAND | | 10a. State
MD. | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 10e. Street and Number
820 S. CATON AVE. | | | | 10f. Zip Code
21229 | | 10g. Citizen of What Country?
U.S.A | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: BLACK | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7TH Collage (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CUSTODIAN | | 16b. Kind of Business/Industry
CITY | | | |
| | 17. Father's Name (First, Middle, Last)
GEORGE B. HOLLIDAY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
SARAH LEE PILUS | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ben Holliday | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
243 McCURLEY ST. BALT. MD. 21229 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
LODGE PARK | | 20c. Location - City or Town, State
2120/97 Woodlawn MD. | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Funeral Home
GARY J. MARCH FUNERAL HOME PA
270 FRED HILTON PASS BALT. MD. 21229 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final disease or condition resulting in death)
WIDELY DISSEMINATED CARCINOMA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
UNKNOWN
Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of): | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MILD TO MODERATE ATHEROSCLEROSIS | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
D41843 | | 29d. Date signed (Month, Day, Year)
February 15, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Ann E. Reed, M.D., St. Agnes Hospital, 900 Caton Avenue, Baltimore, MD 21229 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

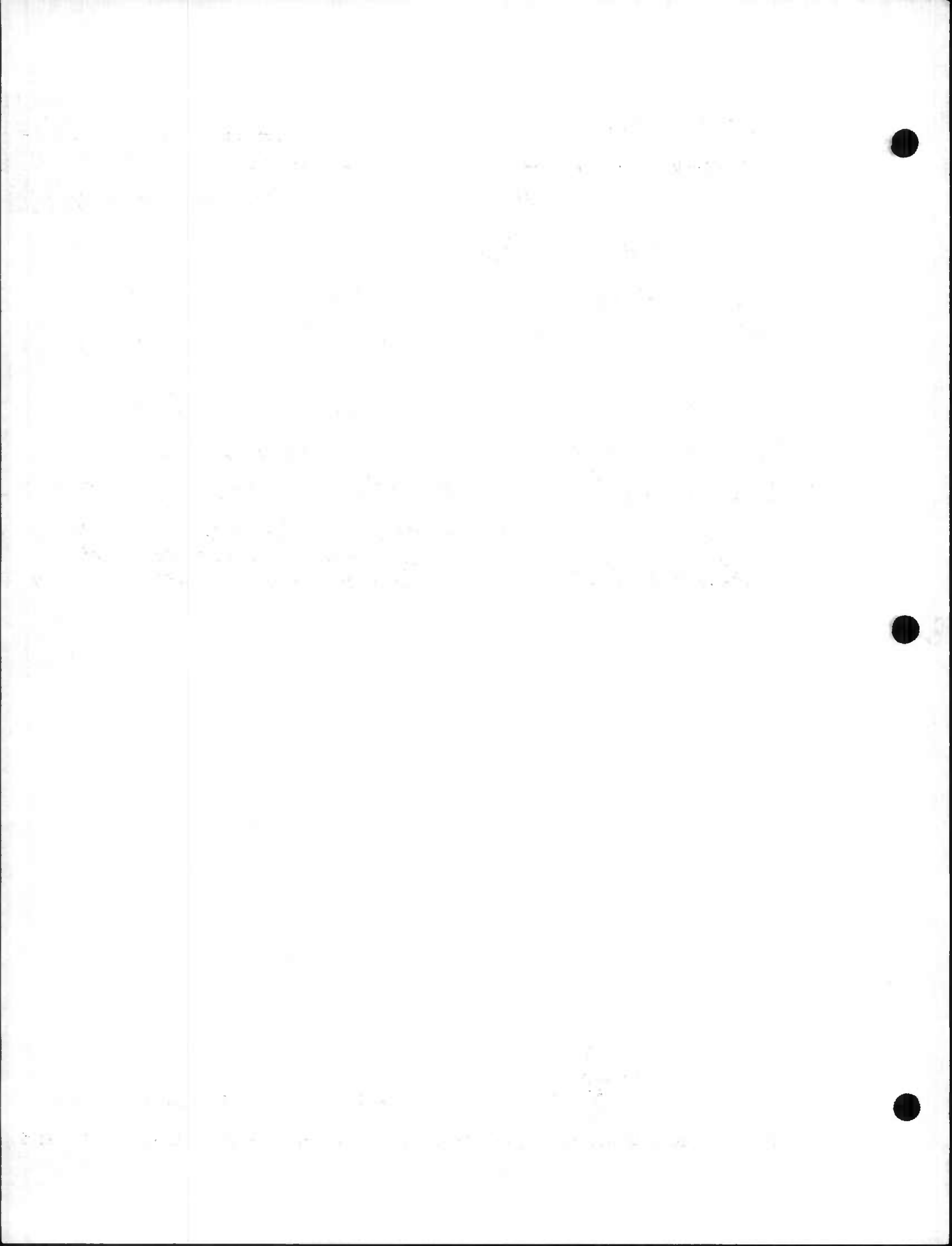
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04444

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen M. Hsu.

2. Date of Death

Feb 15 97

Day Year

3. Time of Death

3:28 AM

4a. Facility Name (If not institution, give street and number)

Howard Co. General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard County

5. Social Security Number

214-88-5835

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-20-1913

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

MD.

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8701 Hayshed Lane, Apt. 21

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Chinese

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Hong C. Mok

18. Mother's Name (First, Middle, Maiden Surname)

Yuen F. (Liao)

19a. Informant's Name/Relationship (Type, Print)

Wai Mee Tang (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1030 Grove Ave. Apt. 27-B, Edison, N. J. 08820

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbia Memorial Park

Date

2/16/97

20c. Location - City or Town, State

Clarksville, Md.

21. Signature of Funeral Service Licensee

Robert Syng Buhn

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.

5555 Twin Knolls Rd., Columbia, Md. 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple organ system failure

Due to (or as a consequence of):

Bilateral Pneumonia, Respiratory failure

Due to (or as a consequence of):

Pancytopenia

Due to (or as a consequence of):

Septic shock

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestive heart failure

Electrolyte imbalance

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ho-Lai Feng, M.D.

29c. License number

D31927

29d. Date signed (Month, Day, Year)

Feb-15-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ho-Lai Feng, M.D. Two Knoll North Dr. Columbia MD 21045

31. Date filed (Month, Day, Year)

Feb 18 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04445

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

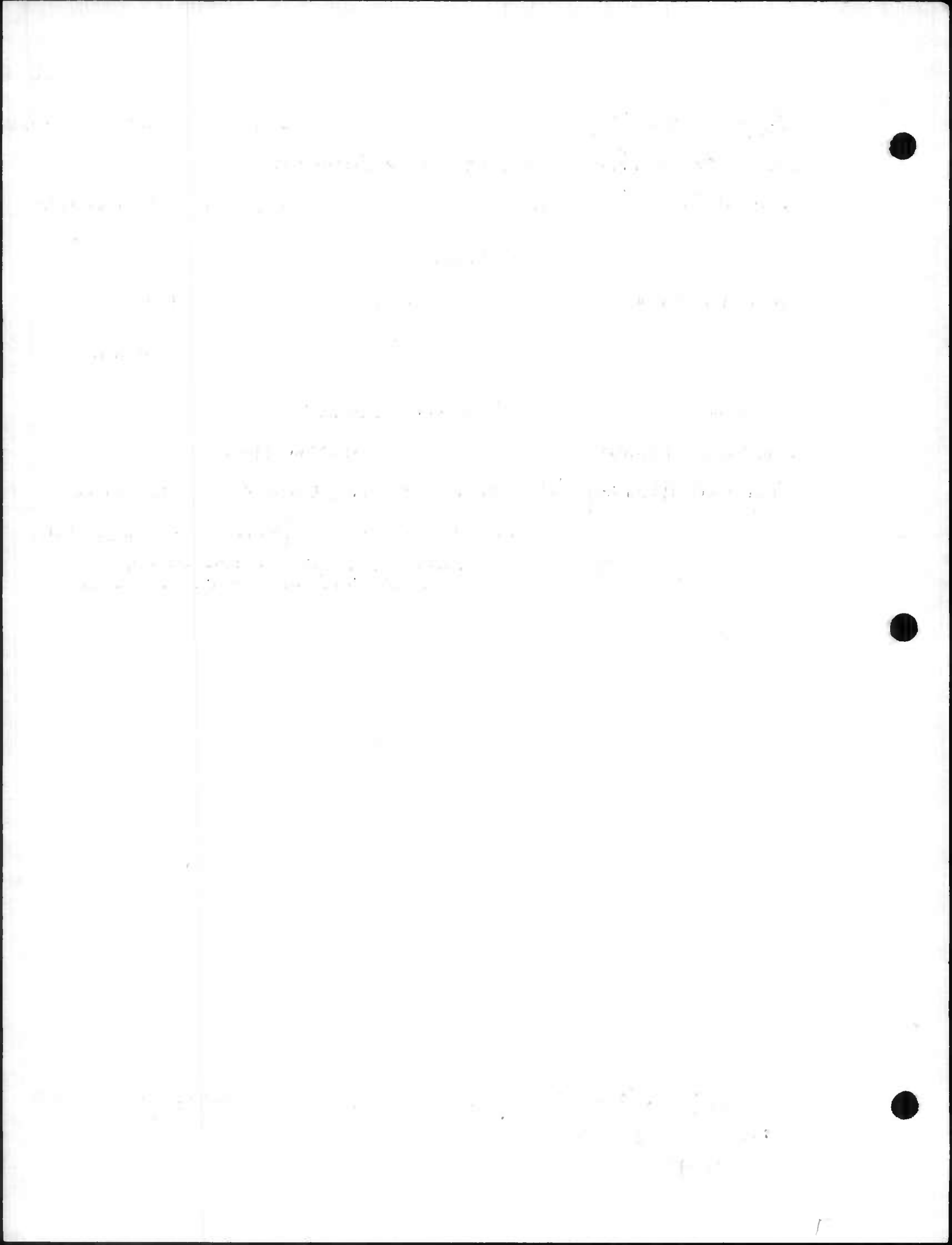
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
<i>Paul Herring</i> | | 2. Date of Death
Month <i>February</i> Day <i>13</i> Year <i>1997</i> | | 3. Time of Death
<i>4:36 AM</i> | |
| 4a. Facility Name (If not institution, give street and number)
<i>Liberty Medical Center, 2600 Liberty Hgts Ave</i> | | 4b. City, Town, or Location of Death
<i>Baltimore</i> | | 4c. County of Death
<i>N/A</i> | |
| 5. Social Security Number
<i>234-32-7049</i> | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>75</i> Yrs. | |
| 8. Date of Birth
Month <i>12</i> Day <i>30</i> Year <i>21</i> | | 9. Birthplace (State or Foreign Country)
<i>WEST VIRGINIA</i> | | | |
| 10a. State
<i>MD</i> | | 10b. County
<i>N/A</i> | | 10c. City, Town or Location
<i>BALTIMORE</i> | |
| 10d. Inalde City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
<i>4104 ALTO ROAD</i> | | 10f. Zip Code
<i>21216</i> | |
| 10g. Citizen of What Country?
<i>USA</i> | | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>BLACK</i> | | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>12 TH</i> College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>MERCHANT SEAMEN</i> | | 16b. Kind of Business/Industry | |
| 17. Father's Name (First, Middle, Last)
<i>BARNABUS HERRING</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>HANNAH HALL</i> | | | |
| 19a. Informant's Name/Relationship (Type, Print)
<i>WILLA MAE HERRING / WIFE</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>4104 ALTO ROAD, BALTIMORE, MD 21216</i> | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory, or other place)
<i>GARRISON FOREST</i> | | 20c. Location - City or Town, State
<i>2/18/97 OWINGS MILLS, MD.</i> | |
| 21. Signature of Funeral Service Licensee
<i>Vaughn C. Green</i> | | 22. Name and Address of Facility
<i>VAUGHN C. GREENE FUNERAL SERVICES
5151 BALTO. NATL PIKE, BALTO. MD. 21229</i> | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. <i>Chronic Pulmonary Obstruction Disease</i>
Due to (or as a consequence of):
b. <i>Asthma</i>
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined
<input type="checkbox"/> Suicide <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
<i>M</i> | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29e. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | |
| 29b. Signature and title of certifier
<i>Charles Fortent</i> | | 29c. License number
<i>DY4151</i> | | 29d. Date signed (Month, Day, Year)
<i>February 16, 1997</i> | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Liberty Medical Center Charles Fortent</i> | | | | | |
| 31. Date filed (Month, Day, Year)
<i>FEB 18 1997</i> | | 32. Registrar's Signature
<i>Julia Harrison</i> | | | |

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04446

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
COWGER, HOWIE | | | | 2. Date of Death
Month Day Year
FEBRUARY 15 1997 | | 3. Time of Death
5:45 AM | | | |
| 4a. Facility Name (If not institution, give street and number)
Johns Hopkins Bayview Med. Center | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | |
| 5. Social Security Number
235-20-9894 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
73 Yrs. | | If Under 1 Year
Months Days | | | |
| 6. Usual Residence of Decedent | | 9. Birthplace (State or Foreign Country)
Sept. 13, 1923 W. Virginia | | 10. Date of Birth (Month, Day, Year) | | 11. Birthplace (State or Foreign Country) | | | |
| 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Edgemere | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 10a. Street and Number
7622 North Point Rd. | | | | 10f. Zip Code
21219 | | 10g. Citizen of What Country?
USA | | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | |
| 15. Decedent's Education (Specify only highest grade completed)
8 yrs. | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Millrite | | 16b. Kind of Business/Industry
Beth. Steel | | | |
| 17. Father's Name (First, Middle, Last)
Willie Cowger | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Tillie Williams | | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Madeline Cowger wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7622 North Point Rd. Edgemere Md. 21219 | | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens Of Faith | | Data
2-18 | | 20c. Location - City or Town, State
Rossville | | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk
7110 Sollers Point Rd 21222 | | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RENAL FAILURE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | Approximate Interval Between Onset and Death
TWO DAYS | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
PERIPHERAL VASCULAR DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | |
| 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 PHYSICIAN | | 29c. License number
N2600 | | 29d. Date signed (Month, Day, Year)
FEBRUARY 15, 1997 | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
SYDNEY MORRIS, MD TOWER 110 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JOHNS HOPKINS HOSPITAL
BALTIMORE, MARYLAND | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | | | | | |

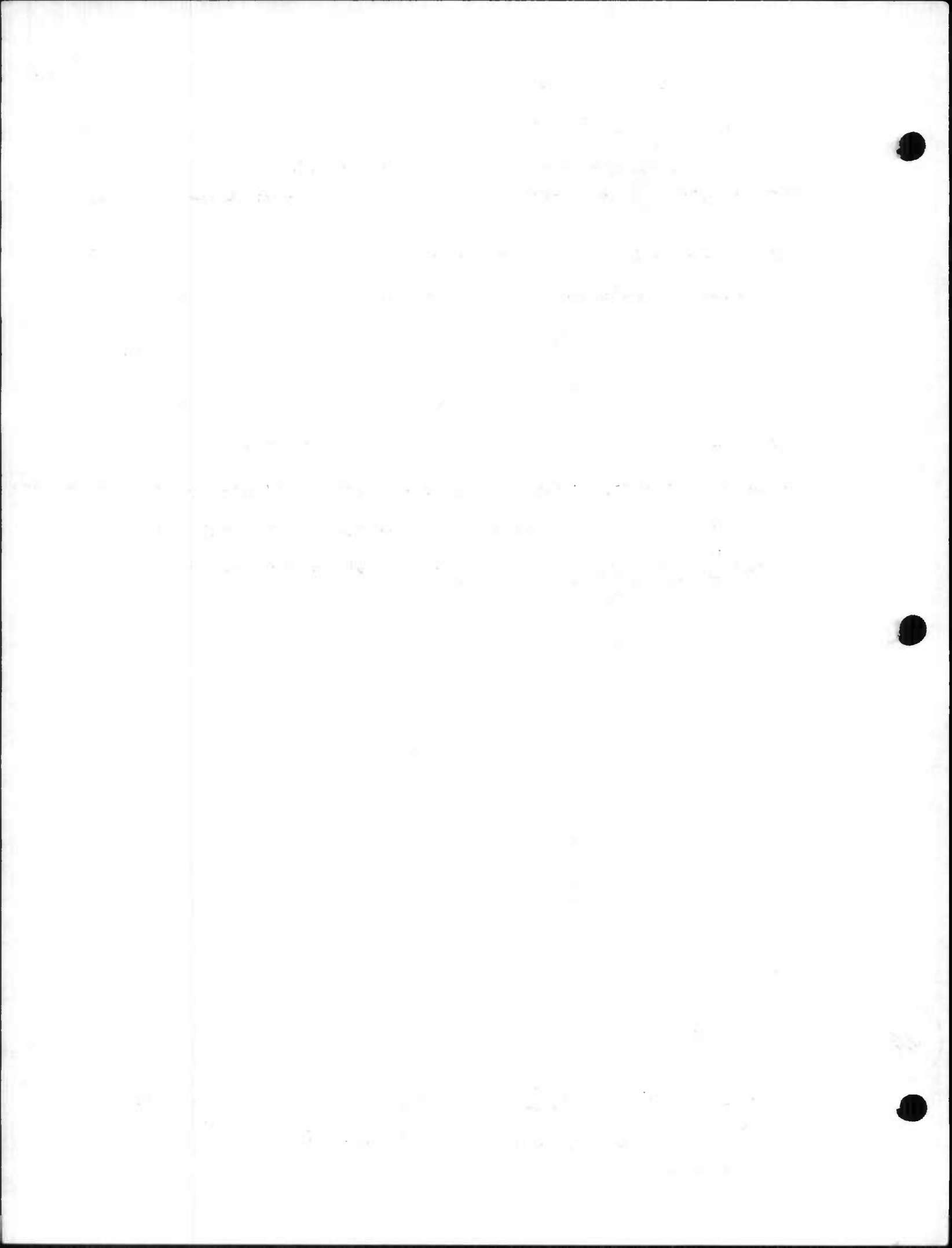
State
Registrar

97 04447

Reg. No.

DMMH 16 Rev 6/95

| | | | | | |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)
<i>Elizabeth Jerome</i> | | 2. Date of Death
Month <i>2</i> Day <i>16</i> Year <i>97</i> | | 3. Time of Death
<i>0913</i> | |
| 4a. Facility Name (If not institution, give street and number)
<i>Carroll County General Hospital</i> | | 4b. City, Town, or Location of Death
<i>Westminster, Md</i> | | 4c. County of Death
<i>Carroll</i> | |
| 5. Social Security Number
<i>206-34-0075</i> | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
<i>78</i> Yrs. | |
| 8. Usual Residence of Decedent
10a. State
<i>Md</i> | | 10b. County
<i>Carroll</i> | | 10c. City, Town or Location
<i>Taneytown</i> | |
| 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
<i>3217 Bert Koontz Road</i> | | 10f. Zip Code
<i>21787</i> | |
| 10g. Citizen of What Country?
<i>USA</i> | | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <i>white</i> | | 15. Decedent's Education (Specify only highest grade completed)
<input type="checkbox"/> Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) | |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Nurse</i> | | 16b. Kind of Business/Industry
<i>Medical</i> | | 17. Father's Name (First, Middle, Last)
<i>Louis Papp</i> | |
| 18. Mother's Name (First, Middle, Maiden Surname)
<i>Anna Garska</i> | | 19a. Informant's Name/Relationship (Type, Print)
<i>Karen J. Offutt/Daughter</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>3616 Black Rock Road/Upperco, Md. 21155-9321</i> | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Chesapeake Crematory</i> | | 20c. Location - City or Town, State
<i>02/18 Beltsville, Md.</i> | |
| 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
<i>Bradley Ashton Funeral Home, Inc
2134 Willow Spring Road, Dundalk, Md 21222</i> | | 23a. Pertinent: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<i>Metastatic Cancer to the Liver from an unknown primary site</i> | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day Year)
<i>2/12/97</i> | | 28b. Time of Injury
<i>M</i> | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 28d. Describe how injury occurred | | 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | |
| 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
<i>D23719</i> | | 29d. Date signed (Month, Day, Year)
<i>2/12/97</i> | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
<i>295 Stover Ave Westminster, Md 21157</i> | | 31. Date filed (Month, Day, Year)
<i>FEB 18 1997</i> | | 32. Registrar's Signature
<i>[Signature]</i> | |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04448

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George

Jackson

2. Date of Death
Month Day Year
February 15 19973. Time of Death
7:35amFuneral
Director

4a. Facility Name (If not institution, give street and number)

5732 Flag Flower Place

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

454-38-0876

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

October 31, 1929

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State
Maryland10b. County
Howard10c. City, Town or Location
Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5732 Flag Flower Place

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Vitro

17. Father's Name (First, Middle, Last)

Henry Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Henry

19a. Informant's Name/Relationship (Type, Print)

Jeraldine Jackson (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5732 Flag Flower Place Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Feb. 27,
Arlington National Cemetery 1997

Date

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

K. G. Witke

22. Name and Address of Facility

Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, Maryland 2104523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Prostate Cancer

Approximate
Interval Between
Onset and Death

4 Yrs.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Nancy A. Dawson M.D.

29c. License number

D31586

29d. Date signed (Month, Day, Year)

2/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04449

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM DAVIES JENKINS, SR.

2. Date of Death

FEB. 15 1997

3. Time of Death

8:35 PM

4a. Facility Name (If not institution, give street and number)

9731 HARFORD ROAD

4b. City, Town, or Location of Death

CARNEY

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

212-14-3021

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1/4/19

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

CARNEY

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9731 HARFORD ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

HOME CONSTRUCTION

17. Father's Name (First, Middle, Last)

ALPHONSUS L. JENKINS

18. Mother's Name (First, Middle, Maiden Surname)

AMY D. COUZENS

19a. Informant's Name/Relationship (Type, Print)

PATRICIA W. JENKINS WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9731 HARFORD ROAD BALTIMORE, MD 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

2/20/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.
TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myeloid leukemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES A. SCHIFFER, MD.

31. Date filed (Month, Day, Year)

FEB 18 1997

31. Registrar's Signature

John Davidson-Randall

State
Registrar

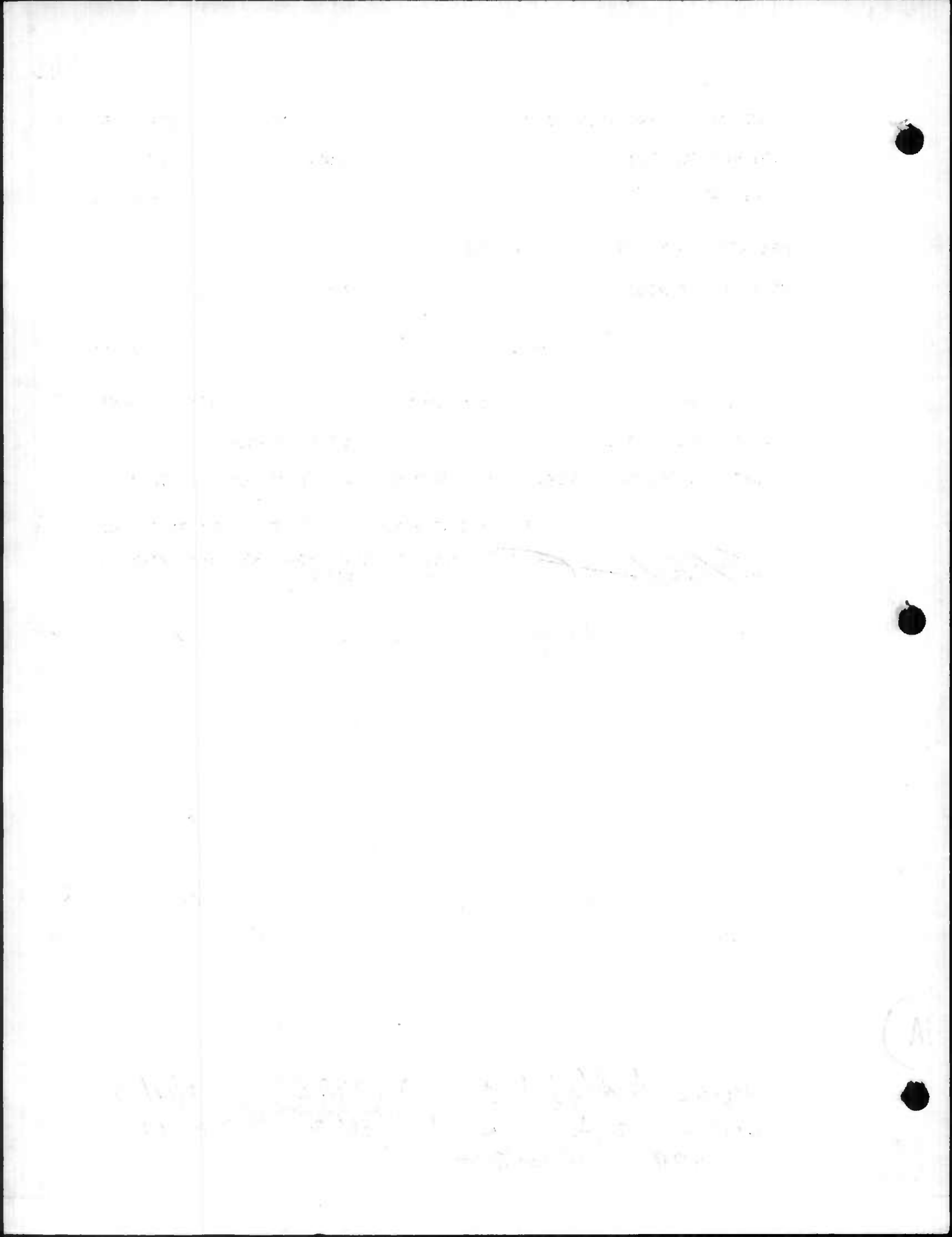
Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020. The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04450

Reg. No.

| | | | | | |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Retha L. King | | 2. Date of Death
Month February Day 14 Year 1997 | | 3. Time of Death
4:25 AM |
| | 4e. Facility Name (If not Institution, give street and number)
Good Samaritan Hospital | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
220-74-5924 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
64 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
FEB 14, 1933 | | 9. Birthplace (State or Foreign Country)
Virginia | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore |
| | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | 10e. Street and Number
2808 Quantico Avenue | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home |
| | 17. Father's Name (First, Middle, Last)
Oscar Thomas | | 18. Mother's Name (First, Middle, Maiden Surname)
Ollie Mosbly | | |
| | 19e. Informant's Name/Relationship (Type, Print)
Charles King/husband | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2808 Quantico Ave, Balto, MD 21215 | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. | | 20c. Location - City or Town, State
Baltimore, MD |
| | 21. Signature of Funeral Service Licensee
George E. MacNabb | | 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Rd. Baltimore, MD 21228 | | |
| Physician
/Medical
Examiner | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia
Due to (or as a consequence of):
b. Metabolic acidosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | Approximate Interval Between Onset and Death
10 days
3 days |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation. Diabetes mellitus | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | |
| | 29b. Signature and title of certifier
Jihad Toussef, MD | | 29c. License number
P10584 | | 29d. Date signed (Month, Day, Year)
February 14, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jihad Toussef, MD 5601 Loch Raven Baltimore MD 21234 | | | | |
| State
Registrar | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
John Davidson | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04451

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARVIN

KOFKY

2. Date of Death

Month Day Year
FEB. 12, 1997

3. Time of Death

12:22AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

095-30-1809

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB. 13, 1940

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3945 LUMO CIRCLE

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

BAGEL SHOP

17. Father's Name (First, Middle, Last)

IRVING

KOFKY

18. Mother's Name (First, Middle, Maiden Surname)

MAE

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

ROBINA KOFKY / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3945 LUMO CIRCLE RANDALLSTOWN, MD 21133

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

UNITED HEBREW

Date

2/16/97

20c. Location - City or Town, State

STATEN ISLAND, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Myocardial infarction with cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

pneumonia

Due to (or as a consequence of):

Renal failure on hemodialysis

Due to (or as a consequence of):

Hypertension

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

No Atrial fibrillation

No diabetes

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46 496

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50 Grameters Mills Rd., Orange Mills, M.D 21117

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

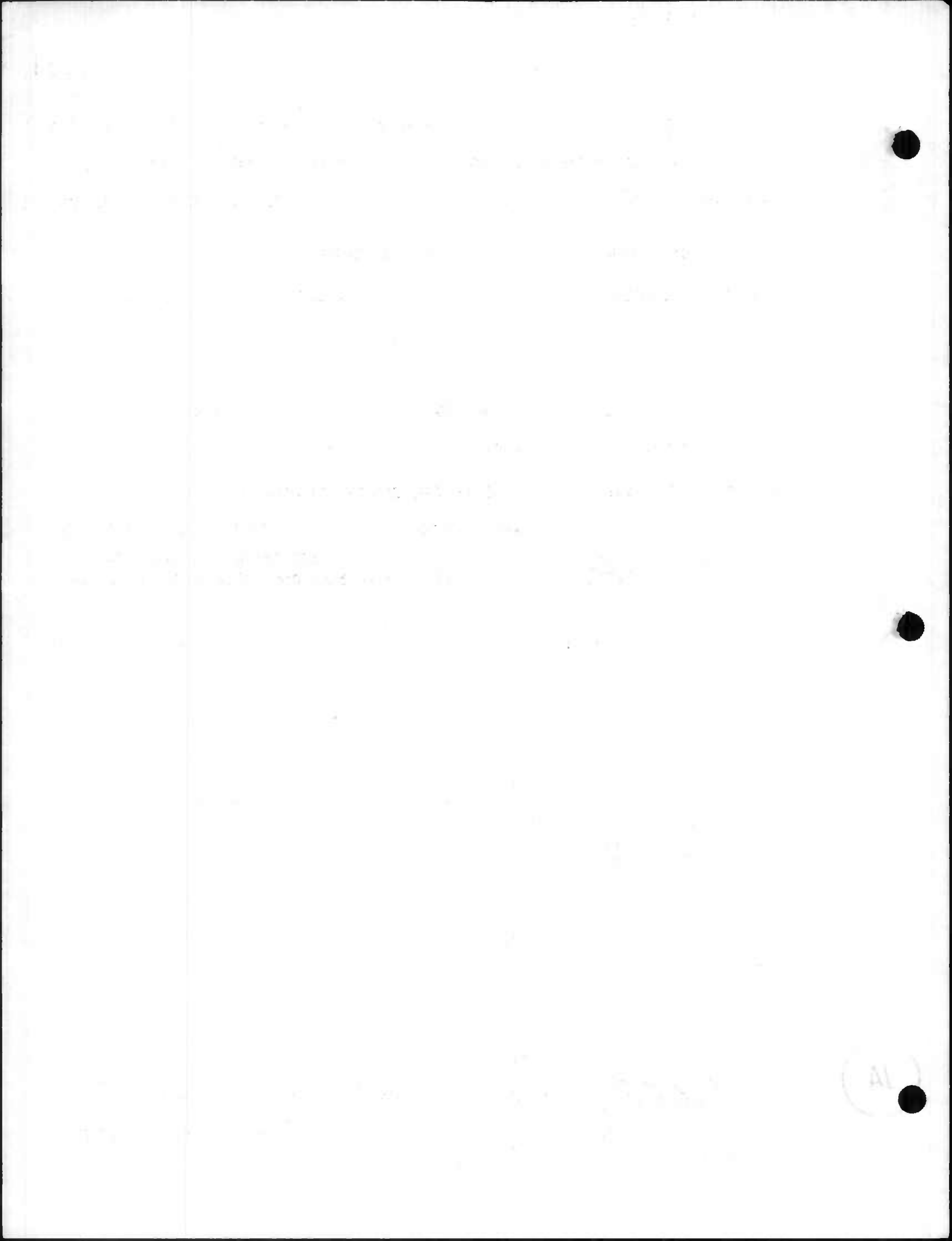
Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04452

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marianne

Katz

2. Date of Death

Month Day Year
FEBRUARY 12, 1997

3. Time of Death

11:50 A

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore City

5. Social Security Number

026-05-6667

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)
June 9, 1914

9. Birthplace (State or Foreign Country)

Fall River, MA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Pleasant Ridge Dr.

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

-8-

College (14 or 5+)

-0-

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

18b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Joao Tavares

18. Mother's Name (First, Middle, Maiden Surname)

Maria Arruda

19a. Informant's Name/Relationship (Type, Print)

Irving M. Katz/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Pleasant Ridge Dr., Owings Mills, MD 21117

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Carroll Cremation Services 2/13/97 Hampstead, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Affy B. El-

22. Name and Address of Facility

Eline Funeral Home
11824 Reisterstown Rd.
Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. mitral valve rupture

8 Days

b. myocardial infarction

8 Days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Karl P. Kuhn

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karl Kuhn, Tower 110 THE JOHNS HOPKINS HOSPITAL

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Signature of Registrar

John R. Rondon

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

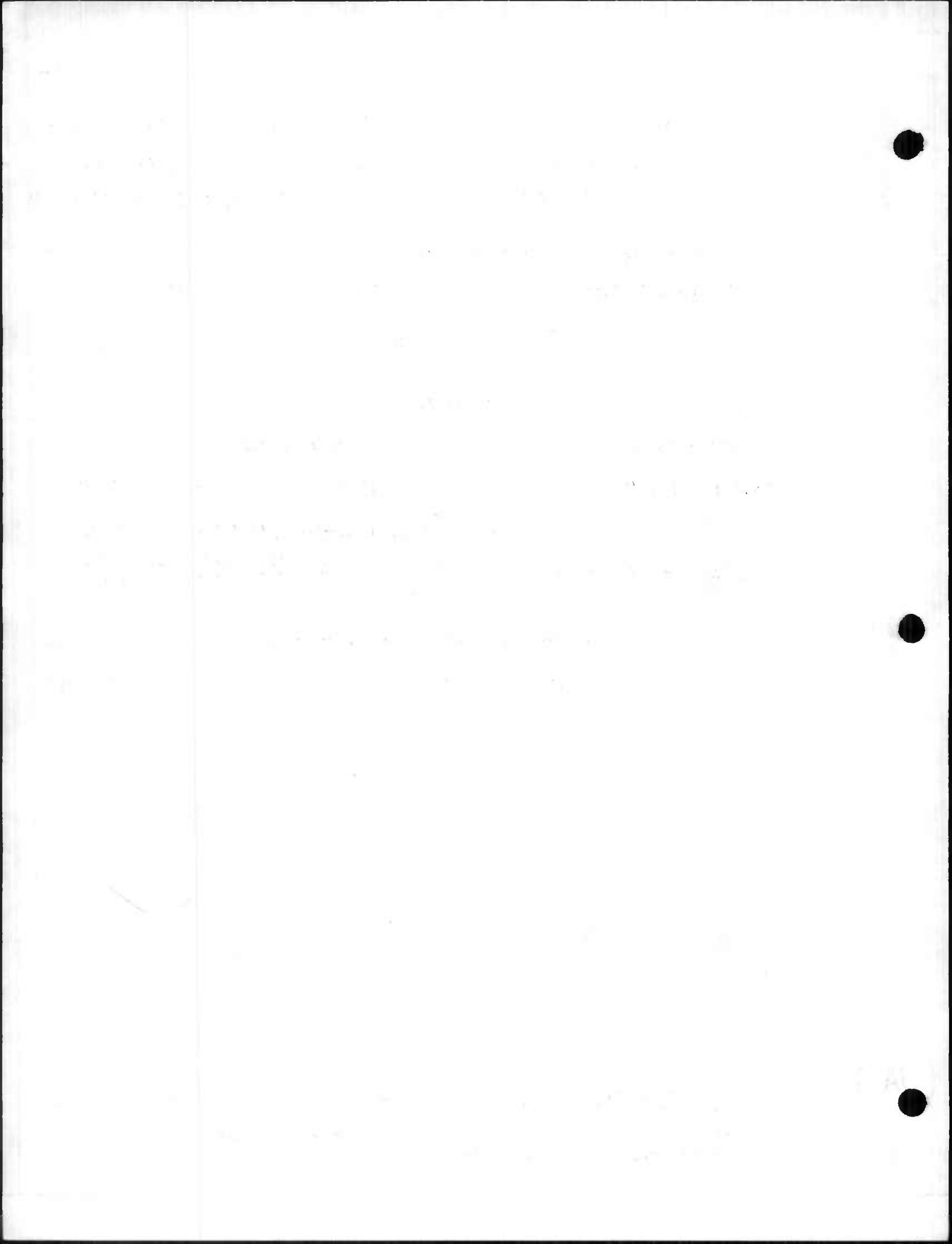
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. After this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items 7, 19a per FH Film G744 2-24-97 rja

Certificate of Death

Reg. No.

97 04453

| | | | | | | | | |
|--|---|--|---|--|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Kathryn J. Kefauver | | | | 2. Date of Death
Month: February Day: 15 Year: 1997 | | 3. Time of Death
12:15 PM | |
| | 4a. Facility Name (If not institution, give street and number)
5445 Baltimore National Pike | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
220-14-4071 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 77 Yrs. | | 8. Date of Birth (Month, Day, Year)
10-11-1919 | |
| | 9. Birthplace (State or Foreign Country)
MD | | 10. Usual Residence of Decedent
10a. State: MD 10b. County: BALTIMORE 10c. City, Town or Location: CATONSVILLE 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: | |
| To Be Completed by Funeral Director | 13. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11 College (1-4or 5+): | | 14. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CLERK | | 15. Kind of Business/Industry
SOCIAL SECURITY | | 16. Father's Name (First, Middle, Last)
JAMES GARY | |
| | 17. Mother's Name (First, Middle, Maiden Surname)
GEORGIA SANC | | 18. Informant's Name/Relationship (Type, Print)
JAMES A. GARY (NEPHEW) | | 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
720 KENT AVENUE CATONSVILLE MD 21228 | | 20. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): | |
| Physician
/Medical
Examiner | 21. Signature of Funeral Service Licensee
<i>R. C. Witke</i> | | 22. Name and Address of Facility
WITZKE FUNERAL HOME OF CATONSVILLE, INC.
1630 EDMONDSON AVENUE CATONSVILLE MD 21228 | | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. Myocardial Infarction Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | |
| | 23c. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Ischemic Cardiomyopathy
Atrial Fibrillation
Atrial Regurgitation | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify): SHOPPING MALL | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
Jonathan S. Sargent MD | | 29c. License number
MARYLAND D41711 | | 29d. Date signed (Month, Day, Year)
FEBRUARY 17, 1997 | |
| State
Registrar | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jonathan Sargent MD 3449 Wilkens Avenue Suite 300 Baltimore, Maryland | | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
<i>Johnston</i> | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97 04454

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)
JOHN KRAHEL | | | | 2. DATE OF DEATH
MONTH FEB DAY 13 YEAR 1997 | | 3. TIME OF DEATH
7:56 PM | |
| 4. SOCIAL SECURITY NUMBER
203-05-5855 | | 5. SEX
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
77 YRS. | | 7. DATE OF BIRTH (Month, Day, Year)
10/27/1919 | |
| 8. BIRTHPLACE (State or Foreign Country)
PENNSYLVANIA | | | | 9a. FACILITY NAME (If not institution, give street and number)
HOWARD COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH
COLUMBIA | |
| 9c. COUNTY OF DEATH
HOWARD | | | | 10. RESIDENCE OF DECEDENT | | | |
| 10a. STATE
MD | | 10b. COUNTY
HOWARD | | 10c. CITY, TOWN OR LOCATION
ELLCOTT CITY | | 10d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 10e. STREET AND NUMBER
7810 OLD FARM LANE | | | | 10f. ZIP CODE
21043 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: | | 14. RACE — American Indian, Black, White, etc.
Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) 10 College (1-4 or 5+) College | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
TRACK MAINTAINER | | 16b. KIND OF BUSINESS/INDUSTRY
TRANSIT AUTHORITY | |
| 17. FATHER'S NAME (First, Middle, Last)
STEPHEN KRAHEL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
ANTOINETTE PANEK | | | |
| 19a. INFORMANT'S NAME (Type/Print)
ANNA KRAHEL/ WIFE | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7810 OLD FARM LANE ELLCOTT CITY, MD 21043 | | | |
| 20a. METHOD OF DISPOSITION
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATORY | | 20c. LOCATION — City or Town, State
2/15/1997 BELTSVILLE | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE
<i>R. Co. Witzke</i> | |
| 22. NAME AND ADDRESS OF FACILITY
WITZKE FUNERAL HOMES | | | | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA
DUE TO (OR AS A CONSEQUENCE OF):
b. ISCHEMIC HEART DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death
SUDDEN
2 YEARS | | | |
| 24a. WAS AN AUTOPSY PERFORMED?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY
M <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28c. INJURY AT WORK?
<input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | 29a. CERTIFIER (Check only one)
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER
<i>William Flowers</i> | | | | 29c. LICENSE NUMBER | | 29d. DATE SIGNED (Month, Day, Year)
FEB 13, 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
William Flowers MD 11055 Little Patuxent Columbia MD | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 18 1997 | | | | 32. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04455

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY JAMES KAUFMAN

2. Date of Death

Month Day Year
FEBRUARY 14, 1997 11:17AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

5. Social Security Number

265-08-2037

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
November 26, 1907

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6401 North Charles Street

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

XXX Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes XXX No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes XXX No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Joseph Kaufman

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Nalley

19a. Informant's Name/Relationship (Type, Print)

Sr.M.Bernice Feilinger SSND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6401 N. Chas St Baltimore, Maryland 21212

20a. Method of Disposition

XXX Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Villa Maria Cemetery

Date

2/17/97

20c. Location - City or Town, State

Glen Arm, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

MONTHS

a. Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No

25. Was case referred to medical examiner?

1 ☐ Yes 2X No

26. Place of Death (Check only one)

Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D16492

29d. Date signed (Month, Day, Year)

February 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEATRIZ P. DIZON, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 18 1997

State
Registrar

Baltimore, Maryland 21215-0020

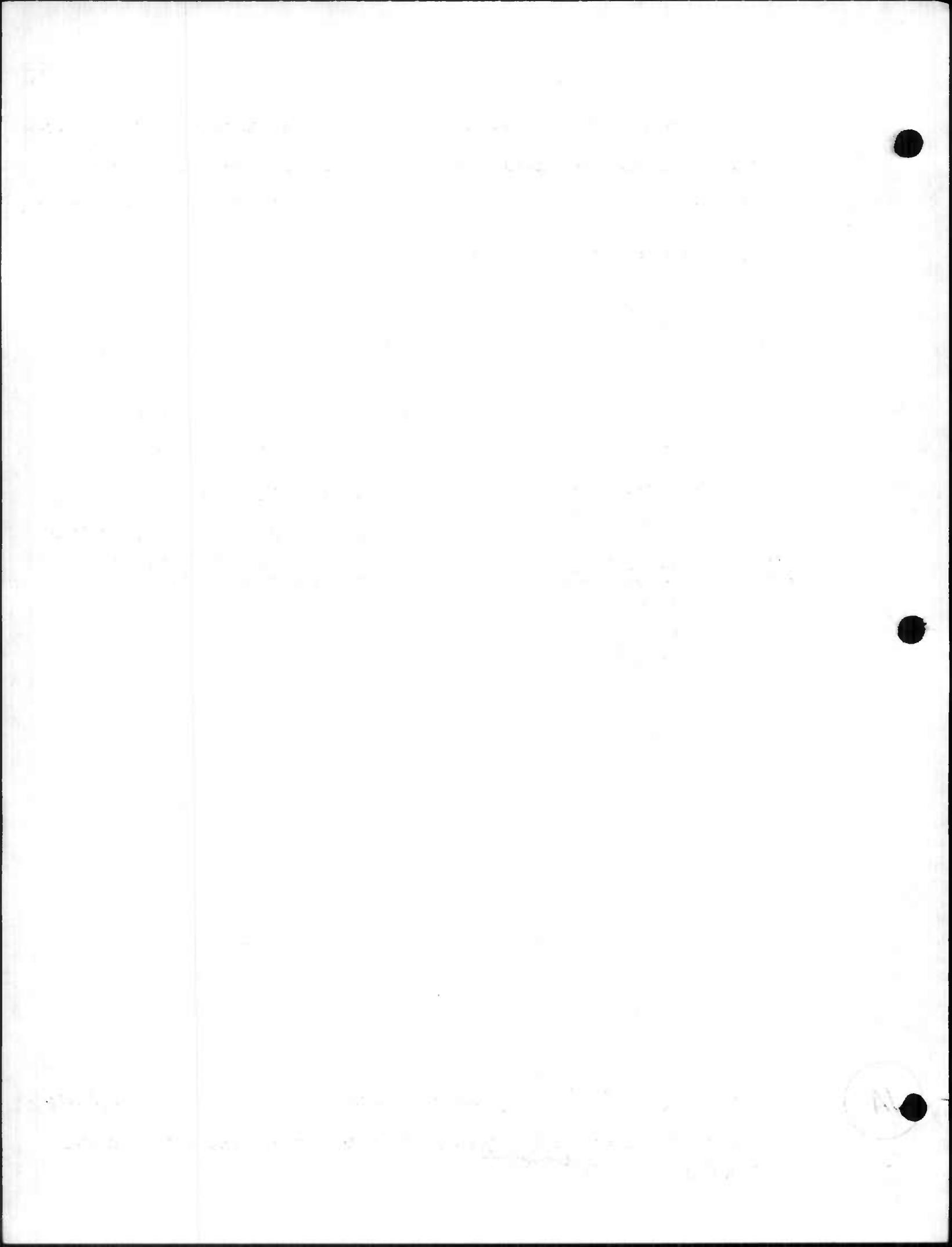
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04456

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles P. Kilduff

2. Date of Death

February 15 1997

3. Time of Death

7:25 AM

4a. Facility Name (If not institution, give street and number)

St. Elizabeth's Rehabilitation Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

216-16-2577

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 4, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll County

10c. City, Town or Location

Finksburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2171 Baltimore Boulevard

10f. Zip Code

21048

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Equipment Manager

16b. Kind of Business/Industry

Construction Co.

17. Father's Name (First, Middle, Last)

John E. Kilduff, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Alice Flanagan

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary M. Kilduff (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2171 Baltimore Blvd., Finksburg, MD 21048

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem.

Date

2/19/97

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Brian L. Haydon

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Parkinson's disease, end-stage
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ OOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Kris E. Kohn MD

29c. License number

D37464

29d. Date signed (Month, Day, Year)

February 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRIS E. KOHN 3421 BENSON AVE. BALTO. MD 21227

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Judy Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

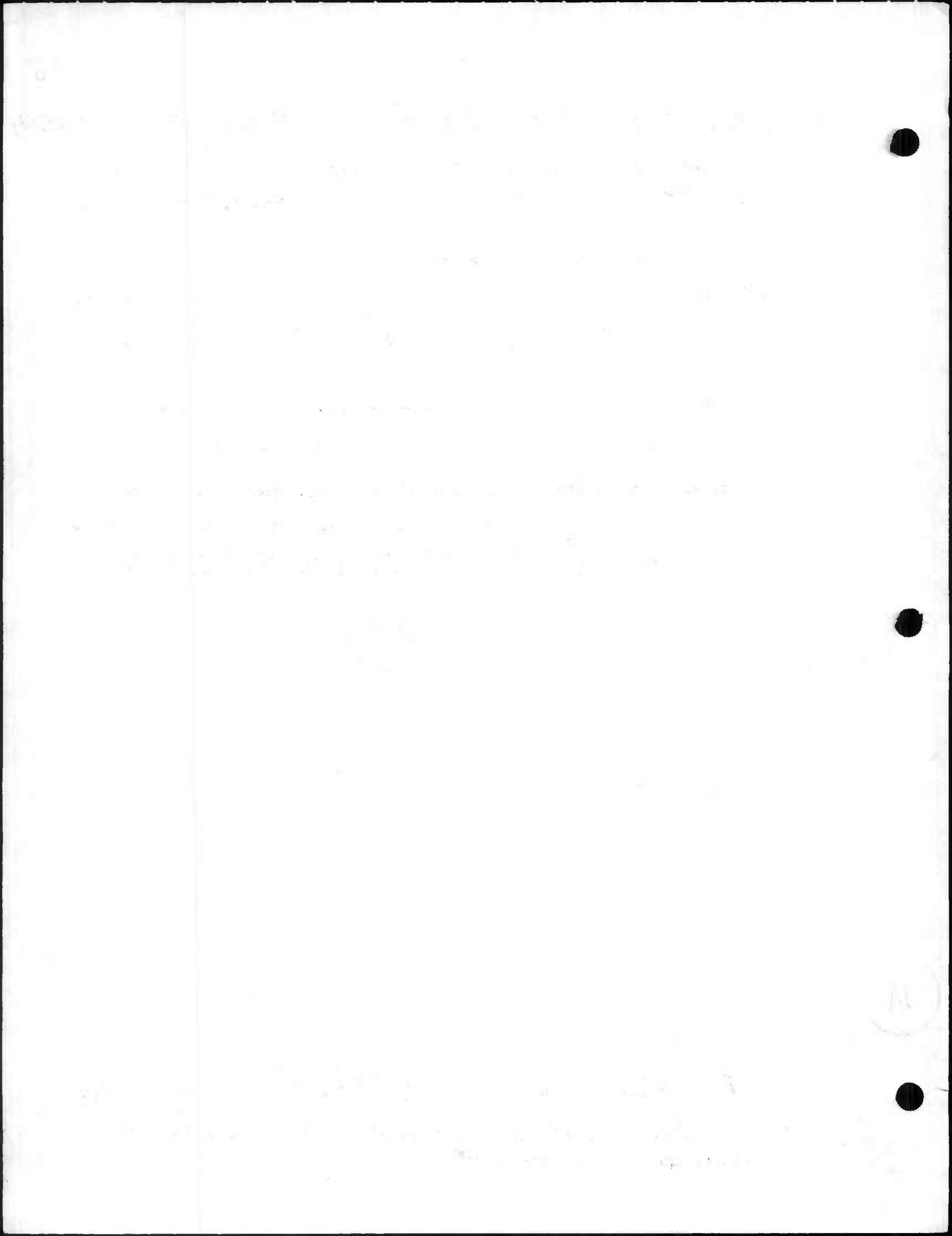
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04457

| | | | | | | | | |
|---|---|---|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ANDREW KENNEALLY | | | | 2. Date of Death
Month February Day 14 , Year 1997 | | 3. Time of Death
8:40 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore County | |
| Funeral
Director | 5. Social Security Number
150-16-4181 | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 31, 1925 | |
| | 9. Birthplace (State or Foreign Country)
New Jersey | | | | | | | |
| Usual Residence of Decedent | | | | | | | | |
| 10a. State
Maryland | | 10b. County
Baltimore County | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| 10e. Street and Number
6401 Loch Raven Boulevard, #138 | | | | 10f. Zip Code
21239 | | 10g. Citizen of What Country?
U.S.A. | | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3 Years College (1-4 or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Accountant | | | 16b. Kind of Business/Industry
City of Baltimore | |
| 17. Father's Name (First, Middle, Last)
Charles Unknown | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Eva Unknown Jones | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Dorothy H. Kenneally / Wife | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6401 Loch Raven Boulevard, #138, Baltimore, Md. 21239 | | | | |
| 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph's Cemetery | | 20c. Location - City or Town, State
Fullerton, Maryland | | |
| 21. Signature of Funeral Service Licensee
<i>Guanda R Thomas</i> | | | | 22. Name and Address of Facility
John C. Miller, Inc.
6415 Belair Road, Baltimore, Maryland 21206 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER
Due to (or as a consequence of):

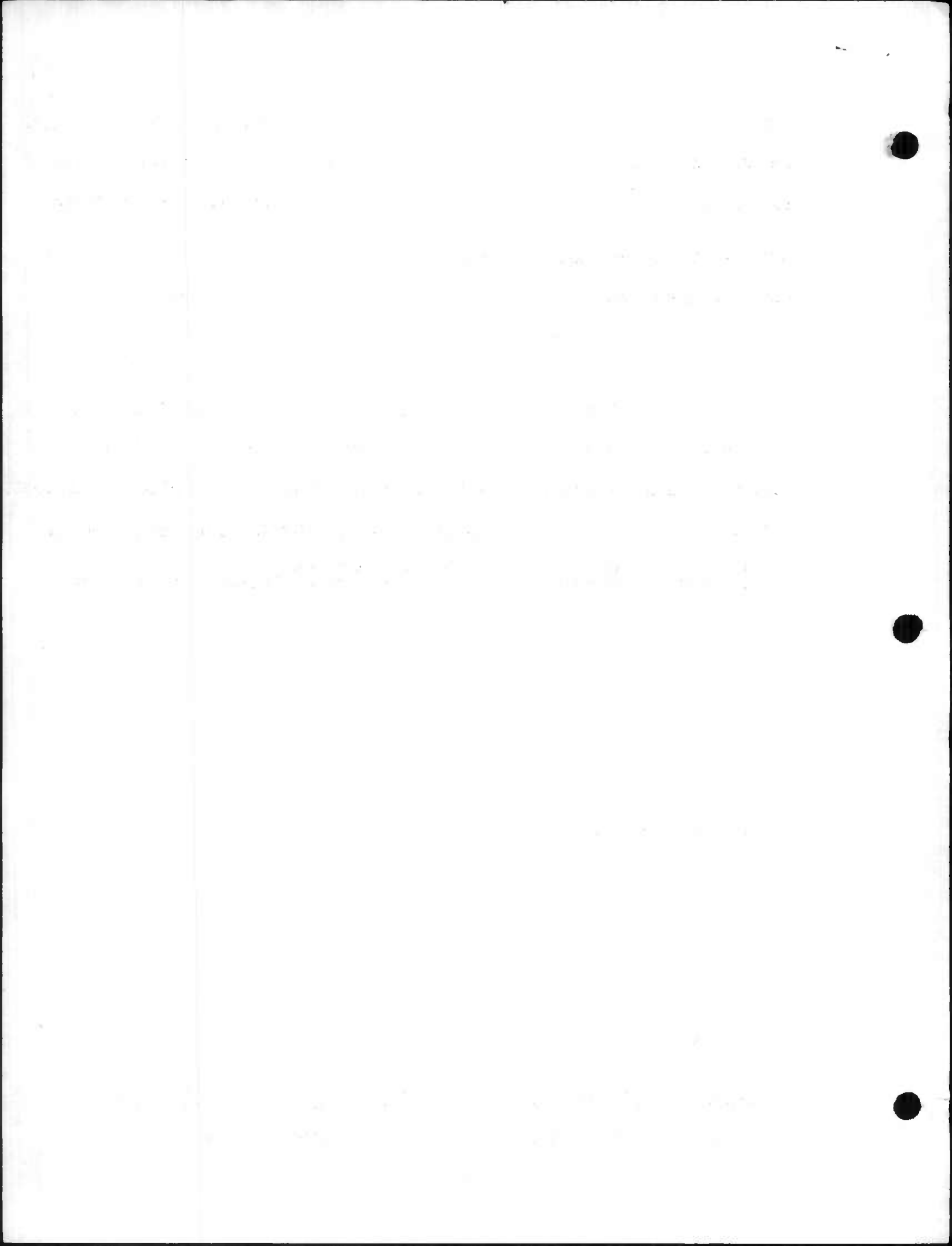
b.
Due to (or as a consequence of):

c.
Due to (or as a consequence of):

d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | |
| Approximate Interval Between Onset and Death
2 mos. | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ENDSTAGE CARDIAC DISEASE | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | 28d. Describe how injury occurred | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Kendall R Faulkner</i> | | | | 29c. License number
D25643 | | 29d. Date signed (Month, Day, Year)
2/14/97 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
<i>John H. ...</i> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04458

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY LOUSIE LAMBERT

2. Date of Death

February 13 1997

3. Time of Death

11:20 AM

4a. Facility Name (If not institution, give street and number)

1508 HARTFORD RD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

217-22-1429

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

1-31-27

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1508 HARTFORD RD. Apt 204

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

GARRISON LOUNGE

17. Father's Name (First, Middle, Last)

CLARENCE LYNCH

18. Mother's Name (First, Middle, Maiden Surname)

LYDIA

19a. Informant's Name/Relationship (Type, Print)

ELAINE WRIGHT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1106 N. MARLYN

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

VOSCHELL CEMETERY

Date

2/19/97 BALTO. MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jeff Miller

22. Name and Address of Facility

1035 N. BROADWAY BALTO. MD. 21213

JEFF MILLER FUNERAL HOME & SERVICE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Heart Failure

Due to (or as a consequence of):

b. Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, Hypertension, Venous Stasis with ulcerations, Past CVA's

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jina B. Robinson MD

29c. License number

D0050704

29d. Date signed (Month, Day, Year)

2-17-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1321 Riverside PKWY Suite A Belcamp, MD 21017

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

J. Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital/Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

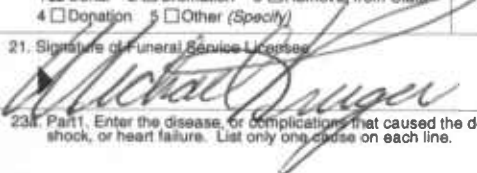
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04459

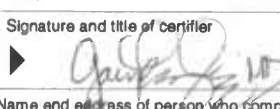

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|---|---|--|---|--|----|--|--|--|--|--|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Betty Levy | | | | 2. Date of Death
Month Day Year
February 13 1997 | | 3. Time of Death
12:35 pm | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Sinai Hospital of Baltimore | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
214-50-6667 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
93 Yrs. | | 8. Date of Birth (Month, Day, Year)
MAY 30, 1903 | | | | | | | | | | | | | | | | |
| | 9. Birthplace (State or Foreign Country)
ILLINOIS | | 10a. State
MARYLAND | | 10b. County
N/A | | 10c. City, Town or Location
BALTIMORE | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 10e. Street and Number
7121 PARK HEIGHTS AVE., APT. 603 | | 10f. Zip Code
21215 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
HOMEMAKER | | 16b. Kind of Business/Industry
OWN HOME | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
LOUIS SUSSMAN | | | | 18. Mother's Name (First, Middle, Maiden Surname)
GOLDE BIENSTOCK | | | | | | | | | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
MRS. GLORIA ASKIN (DAUGHTER) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3404 OLD COURT ROAD BALTIMORE, MD 21208 | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
HAR SINAI | | 20c. Location - City or Town, State
2-14-1997 OWINGS MILLS, MD | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 | | | | | | | | | | | | | | | | | | |
| | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death)

 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Longestive heart failure
Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Critical aortic stenosis
Due to (or as a consequence of):</td> </tr> <tr> <td>c. Pneumonia
Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Longestive heart failure
Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. Critical aortic stenosis
Due to (or as a consequence of): | c. Pneumonia
Due to (or as a consequence of): | d. | | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Longestive heart failure
Due to (or as a consequence of): | Approximate Interval Between Onset and Death | | | | | | | | | | | | | | | | | | | | |
| b. Critical aortic stenosis
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| c. Pneumonia
Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | |
| d. | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers dementia, arrhythmia | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> <td colspan="4">24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="4">24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table> | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | |
| 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | | | | | | | | | | | |
| | | 28d. Describe how injury occurred | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
6K 9062 | | 29d. Date signed (Month, Day, Year)
February 13, 1997 | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
2401 W. Belvedere Avenue Baltimore, MD 21215 | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04460

| | | | | | | | | |
|--|--|--|---|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Roger, , Legere | | | | 2. Date of Death
Month Day Year
FEBRUARY 16, 1997 | | 3. Time of Death
4:10PM | |
| | 4a. Facility Name (If not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
002-42-4533 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
45 Yrs. | | 8. Date of Birth (Month, Day, Year)
April 5, 1951 | |
| | 9. Birthplace (State or Foreign Country)
Maine | | 10a. State
Maryland | | 10b. County
Howard | | 10c. City, Town or Location
Columbia | |
| To Be Completed by
Funeral Director | Usual Residence of Decedent | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 10e. Street and Number
10910 Olde Woods Way | | | | 10f. Zip Code
21044 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Administration | | 16b. Kind of Business/Industry
Education | | | |
| | 17. Father's Name (First, Middle, Last)
Alban Legere | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Almanza P. Bourassa | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Ethel Maggio (P.O.D.-Friend) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10258 Globe Drive Ellicott City, Maryland 21042 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | 20c. Location - City or Town, State
Beltsville, Maryland | | 20d. Date
February 19, 1997 | |
| | 21. Signature of Funeral Service Licensee
<i>K. Coy Withers</i> | | | | 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Liver Failure
Due to (or as a consequence of):
b. Cirrhosis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Renal Failure | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | | | | |
| 28a. Date of Injury (Month, Day, Year)
February 16, 1997 | | | | | | | | |
| 28b. Time of Injury
M | | | | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | |
| 28d. Describe how injury occurred | | | | | | | | |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Ethel Maggio</i> Medical Intern | | | | | | | | |
| 29c. License number
RES-000 | | | | | | | | |
| 29d. Date signed (Month, Day, Year)
February 16, 1997 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ETHAN J. WEISS, M.D. TOWER 110 Doctor's Lounge Johns Hopkins | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | | | | | |
| 32. Registrar's Signature
<i>Ethel Maggio</i> | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or attending physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04461

| | | | | | | | | |
|--|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Edwin G. Lages | | | | 2. Date of Death
Month Day Year
Feb. 10, 1997 | | 3. Time of Death
10:50 P.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Old Court Nursing Home | | | | 4b. City, Town, or Location of Death
Randallstown | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-01-9183 | | 6. Sex
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
88 Yrs. | | 8. Date of Birth (Month, Day, Year)
Dec 21, 1908 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
Baltimore | | 10c. City, Town or Location
Rockdale | |
| To Be Completed by Funeral Director | Usual Residence of Decedent
10a. State
Maryland | | | | 10b. County
Baltimore | | 10c. City, Town or Location
Rockdale | |
| | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 10e. Street and Number
3610 Langrehr Rd. | | 10f. Zip Code
21244 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
4 years | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
CPA | | | | 16b. Kind of Business/Industry
Accounting Firm | | 17. Father's Name (First, Middle, Last)
George Henry Lages | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Mollie Katherine Pahl | | | | 19a. Informant's Name/Relationship (Type, Print)
Myrtle Lages (Wife) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3610 Langrehr Rd. Baltimore, MD 21244 | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation, Inc | | 20c. Location - City or Town, State
2-13-97 Hampstead, Maryland | |
| | 21. Signature of Funeral Service Licensee
John K. Ayala | | | | 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc.
8728 Liberty Rd. Randallstown, MD 21133 | | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Severe cerebrovascular accident
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | |
| 28a. Date of Injury (Month, Day, Year) | | | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28d. Describe how injury occurred | | | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
F. Kawaja | | 29c. License number
D25112 | | |
| 29d. Date signed (Month, Day, Year)
Feb. 11, 1997 | | | | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
TAHOORA KAWAJA 5310 Old Court Rd Randallstown MD 21133 | | 31. Date filed (Month, Day, Year)
FEB 15 1997 | | |
| 32. Registrar's Signature
Julia Davidson-Randall | | | | 33. Registrar's Title
Registrar | | 34. Registrar's Office
DHHM 16 Rev 6/95 | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04462

| | | | | | | | | |
|---|---|--|--|--|---|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
JACQUELINE MATTHEWS | | | | 2. Date of Death
Month 02 Day 12 Year 97 | | 3. Time of Death
2:50 pm | |
| | 4a. Facility Name (If not institution, give street and number)
BON SECOUR Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
NA | |
| Funeral
Director | 5. Social Security Number
217-54-2599 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
45 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB 7, 1952 | |
| | 9. Birthplace (State or Foreign Country)
md | | 10a. State
md | | 10b. County
NA | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 10e. Street and Number
1206 David Hill Ave. | | 10f. Zip Code
21217 | |
| | 10g. Citizen of What Country?
USA | | | | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12th College (1-4 or 5+) NA | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Beautician | | | | 16b. Kind of Business/Industry
Beauty Salons | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
Charles E. Matthews | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Arlene Matthews | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Michael Matthews - Bro. | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3604 Harlem Ave. Balto. md. 21229 | | | |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ussell Mem. Garden | | 20c. Location - City or Town, State
Balto. md. | |
| | 21. Signature of Funeral Service Licensee
Thymis B. Harris | | | | 22. Name and Address of Facility
March Funeral Home - West
4300 Wabash Ave. Balto. md. 21215 | | | |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
Acute Respiratory Failure
Due to (or as a consequence of):
Acute Liver Failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Coagulopathy
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Anemia | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | |
| | 28c. Injury et Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 28d. Describe how Injury occurred | | | |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | 29b. Signature and title of certifier
Radcliffe M Thomas | | | |
| To Be Completed by Physician/Medical Examiner | 29c. License number
442683 | | | | 29d. Date signed (Month, Day, Year)
02/15/97 | | | |
| | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
RADCLIFFE M THOMAS | | | | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature
Davidson | | | | 33. Date of Death
MD 21215 | | | |
| | 34. State Registrar
FEB 18 1997 | | | | 35. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04463

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Doris M. Mears

2. Date of Death

Month Day Year
Feb. 15, 1997

3. Time of Death

8:20pm

4a. Facility Name (If not Institution, give street and number)

Good Samaritan Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

218-09-6238

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 16, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

845 West 37th Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (1-4or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Manager

16b. Kind of Business/Industry

G. C. Murphy Co.

17. Father's Name (First, Middle, Last)

Robert Clark

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Fisher

19a. Informant's Name/Relationship (Type, Print)

John Mears (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3939 Roland Avenue, Apt 518, Baltimore, Md 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Mem Park

Date

2/1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home

3818 Roland Avenue, Baltimore, Md 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ASCVD
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Alan Seitz, Jr.

29c. License number

D28987

29d. Date signed (Month, Day, Year)

2-17-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CARL SPERLING, MD. 5601 LOCH RAVEN BLVD BALTO. MD 21239

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

A. Alan Seitz, Jr.

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04464

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Esther M. McFadden

2. Date of Death
Month Day Year

February 17, 1997

3. Time of Death

1:20 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-14-0698

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 18, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3703 Keswick Road

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Jarman Motor Co

17. Father's Name (First, Middle, Last)

Glen Springer

18. Mother's Name (First, Middle, Maiden Surname)

Flora Andrews

19a. Informant's Name/Relationship (Type, Print)

Maurice T. McFadden, Sr. (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3703 Keswick Road, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Cemetery

Date

02/19/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home
3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial ischemia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 hours

Sequently list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular accident
Due to (or as a consequence of):

10 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dany Shampoun, M.D.

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

February 17, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANY SHAMPOUN, M.D. Union Memorial Hospital

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

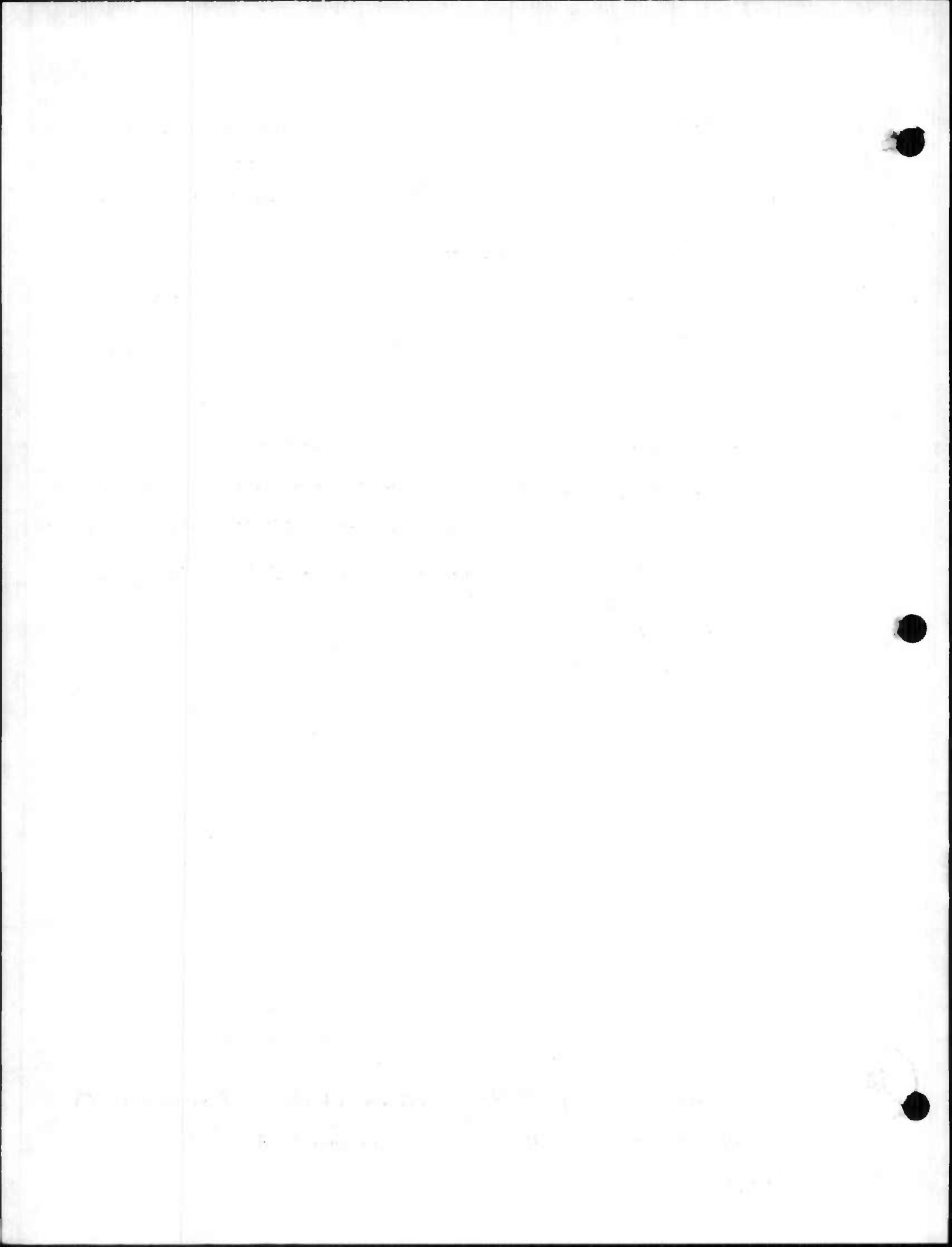
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04465

Reg. No.

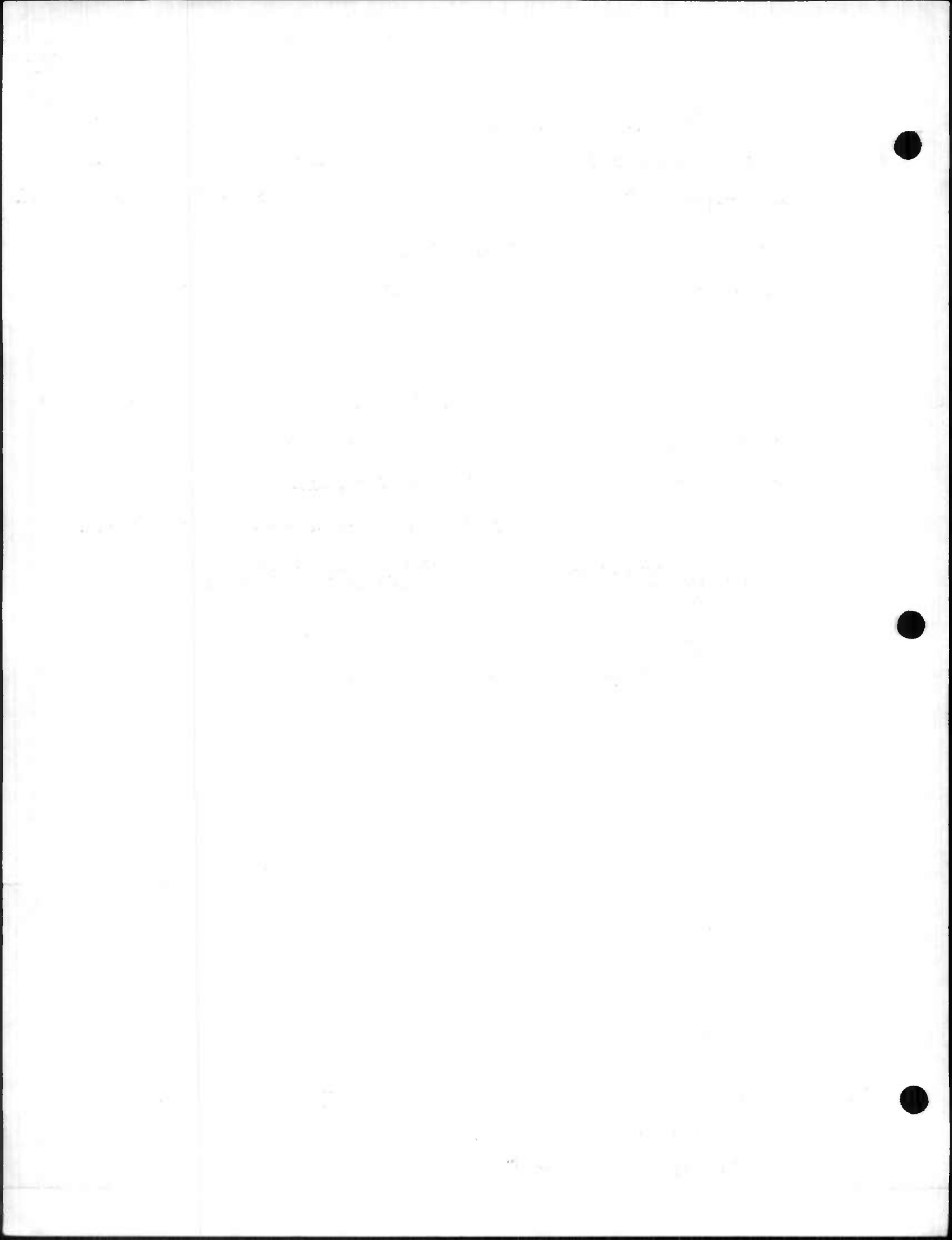
| | | | | | | | | |
|--|---|--|--|--|---|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
ALLEN MANUEL | | | | 2. Date of Death
Month February Day 4 Year 1997 | | 3. Time of Death
9:45 AM | |
| | 4a. Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL | | | | 4b. City, Town, or Location of Death
CHEVERLY, MD | | 4c. County of Death
PRINCE GEORGES | |
| Funeral
Director | 5. Social Security Number
579-44-1092 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
6-29-1912 | 9. Birthplace (State or Foreign Country)
SPOKANE, WASH. |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
PRINCE GEORGES | | 10c. City, Town or Location
MITCHELLEVILLE | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 10e. Street and Number
10450 LOTTSFORD ROAD | | | | 10f. Zip Code
20721 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 6TH College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
FISCAL ECONOMIST | | 16b. Kind of Business/Industry
FEDERAL GOVERNMENT | | | |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)
ARTHUR DAILEY | | | | 18. Mother's Name (First, Middle, Maiden Surname)
AGNES JOHNSON | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
SARAH PORTER | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
205 HILLMOOR DR. SILVER SPRING, MD 20901 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
GEORGETOWN MEDICAL SCHL. | | 20c. Location - City or Town, State
WASHINGTON, D.C. | | 20d. Date
2-4-97 | |
| | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | | 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH ST NW WASH DC 20011 | | | | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial Infarction
Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | Approximate Interval Between Onset and Death
12 years |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | |
| | 29b. Signature and title of certifier
<i>[Signature]</i> | | 29c. License number
D25079 | | 29d. Date signed (Month, Day, Year)
2/7/97 | | | |
| State Registrar | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR H. YABLONCOWITZ, M.D. 7404 EXECUTIVE PL. SEABROOK, MD. 20706 | | | | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

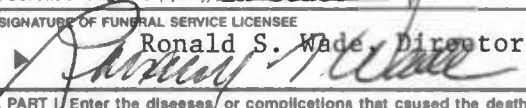
Division of Vital Records, P.O. Box 68760,



97 04466

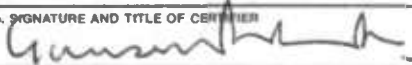

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)
Albert Cletus Mitzel | | | | 2. DATE OF DEATH
MONTH DAY YEAR
Feb 10th 1997 | | 3. TIME OF DEATH
09:18Hrs M | |
| 4. SOCIAL SECURITY NUMBER
213-30-8551 | | 5. SEX
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | | 6. AGE (In yrs. last birthday)
79 YRS. | | 7. DATE OF BIRTH
(Month, Day, Year)
May 15, 1917 | |
| 9a. FACILITY NAME (If not institution, give street and number)
228 Seneca Ave | | | | 9b. CITY, TOWN OR LOCATION OF DEATH
Havre De Grace | | 9c. COUNTY OF DEATH
Harford | |
| 10a. STATE
Maryland | | | | 10b. COUNTY
Harford | | 10c. CITY, TOWN OR LOCATION
Havre De Grace | |
| 10d. INSIDE CITY LIMITS?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | | | | | | |
| 10e. STREET AND NUMBER
228 Seneca Ave. | | | | 10f. ZIP CODE
21078 | | 10g. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 11. MARITAL STATUS
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
IF YES, GIVE WAR OR DATES
unknown | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
Specify:
unknown | | 14. RACE — American Indian, Black, White, etc.
Specify:
white | |
| 15. DECEDENT'S EDUCATION
(Specify only highest grade completed)
Elementary/Secondary (0-12) unknown
College (1-4 or 5+) unknown | | 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.)
unknown | | 16b. KIND OF BUSINESS/INDUSTRY
unknown | | | |
| 17. FATHER'S NAME (First, Middle, Last)
unknown | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname)
unknown | | | |
| 19a. INFORMANT'S NAME (Type/Print)
unknown | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
unknown | | | |
| 20a. METHOD OF DISPOSITION
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in-state | | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)
DATE | | 20c. LOCATION — City or Town, State | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE

Ronald S. Wade, Director | | | | 22. NAME AND ADDRESS OF FACILITY
State Anatomy Board, 655 W. Baltimore St.
Baltimore, Maryland 21201 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final diseases or condition resulting in death) → a. ASCVD
DUE TO (OR AS A CONSEQUENCE OF):

Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d. | | | | | | | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> | | | | | | | 24a. WAS AN AUTOPSY PERFORMED?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO | | 26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA
OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. MANNER OF DEATH
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Not determined
4 <input type="checkbox"/> Homicide | | 28a. DATE OF INJURY (Month, Day, Year)
NA | | 28b. TIME OF INJURY
NA M | | 28c. INJURY AT WORK?
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | |
| 28d. DESCRIBE HOW INJURY OCCURRED
NA | | | | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
NA | | | |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
NA | | | | | | | |
| 29a. CERTIFIER (Check only one)
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER

DME | | | | 29c. LICENSE NUMBER
OCME | | 29d. DATE SIGNED (Month, Day, Year)
Feb 10 1997 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
G.S. Prabhu M.D. 1810 Belair Rd # 102 F 11ston MD. 21047 410-879-6564 | | | | | | | |
| 31. DATE FILED (Month, Day, Year)
FEB 18 1997 | | | | 32. REGISTRAR'S SIGNATURE
 | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04467

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
PERDY MCCORMICK | | 2. Date of Death
Month Day Year
JANUARY 19, 1997 | | 3. Time of Death
1345PM |
| | 4a. Facility Name (If not institution, give street and number)
500 BLOCK GUILFORD AVENUE-UNDER BRIDGE | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
NA |
| Funeral
Director | 5. Social Security Number
unknown | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
71 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Dec. 10, 1926 | | 9. Birthplace (State or Foreign Country)
unknown | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | | | |
| | 10a. State
unknown | 10b. County
unknown | 10c. City, Town or Location
unknown | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input type="checkbox"/> No
unknown |
| | 10a. Street and Number
unknown | | 10f. Zip Code
unknown | | 10g. Citizen of What Country?
unknown |
| | 11. Marital Status
<input type="checkbox"/> Navar Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates:
unknown | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input type="checkbox"/> No Specify: unknown |
| | 14. Race - American Indian, Black, White, etc.
Specify: black | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) unknown
Collega (1-4 or 5+) unknown | | |
| | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
unknown | | 16b. Kind of Business/Industry
unknown | | |
| | 17. Father's Name (First, Middle, Last)
unknown | | 18. Mother's Name (First, Middle, Maiden Surname)
unknown | | |
| | 19a. Informant's Name/Relationship (Type, Print)
unknown | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
unknown | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in-state | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
unknown | | 20c. Location - City or Town, State
unknown |
| | 21. Signature of Funeral Service Licensee
Ronald S. Wade, Director | | 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201 | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Atherosclerotic Cardiovascular disease
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death |
| | b. Due to (or as a consequence of): | | | | |
| | c. Due to (or as a consequence of): | | | | |
| | d. Due to (or as a consequence of): | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year)
unknown | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred
unknown | | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
unknown | | 28f. Location (Street and Number or Rural Route Number, City or Town, State)
unknown | | |
| | 29a. Certifier (Check only one)
<input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | |
| | 29b. Signature and title of certifier
[Signature] | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
JANUARY 20, 1997 |
| | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201 | | | | |
| | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
[Signature] | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04468

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER MARTIN

2. Date of Death

JAN. 30, 1997

3. Time of Death

1525 P

4a. Facility Name (If not institution, give street and number)

2210 ROUND RD APT. T1

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

212-28-7974

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 22, 1923

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2210 Round Rd. Apt. T1

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: unknown

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) unknown
College (1-4 or 5+) unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in-state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street
Baltimore, Maryland 21201

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

Inspection

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JAN. 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04469

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BELLA

MENDELSON

2. Date of Death

Month Day Year
FEB. 12, 1997

3. Time of Death

4:30AM

4a. Facility Name (If not institution, give street and number)

MILFORD MANOR NURSING HOME

4b. City, Town, or Location of Death

PIKESVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

213-16-5433

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 31, 1900

9. Birthplace (State or Foreign Country)

RUSSIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7020 FIELDCREST ROAD

10f. Zip Code

212215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LOUIS

SCHWABSKY

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER

EGLIEN

19a. Informant's Name/Relationship (Type, Print)

FRANK MENDELSON / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6317 PARK HEIGHTS AVE. #111 BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBREW YOUNG MENS

Date

2/13/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Page Feltman

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.
8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Anterior wall myocardial infarction*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicidal 4 ☐ Homicidal
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard B. Cohen

29c. License number

221680

29d. Date signed (Month, Day, Year)

February 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6717 PARK HEIGHTS AVENUE BALTIMORE, MD

Dr. Howard Cohen

21215

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John W. Parker

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or attending physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04470

| | | | | | | | | | | | | | | | |
|---|--|--|---|--------------------------|--|--|--|--|--|---|--|-------------------------------|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Wanda MURR | | | | 2. Date of Death
Month Day Year
February 14, 1997 | | | | 3. Time of Death
7:00 P.M. | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rossville | | | | 4c. County of Death
Baltimore | | | | | | |
| Funeral
Director | 5. Social Security Number
212-30-5197 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | | 7. Age (In yrs. last birthday)
64 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 10, 1933 | | 9. Birthplace (State or Foreign Country)
New Jersey | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | | | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | |
| | 10e. Street and Number
1000 Franklin Ave. | | | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
USA | | | | | | | | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: White | | | | | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
12th | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Housewife | | | 16b. Kind of Business/Industry
own home | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
William Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Ella Moore | | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Melanie Cook /daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2551 Barrison Point Road Baltimore Md. 21221 | | | | | | | | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 2/15/97 | | Date
2/15/97 | | 20c. Location - City or Town, State
Baltimore Md. | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
R. Terry Connelly | | | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 Mace Ave. Baltimore MD. 21221 | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. End stage renal failure
Due to (or as a consequence of):
b. Insulin dependent diabetes mellitus
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | Approximate Interval Between Onset and Death
2 years | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic cardiovascular disease
Atrial fibrillation | | | | | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown | | | | |
| 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 28d. Describe how injury occurred | | | | | | | |
| | | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | 29b. Signature and title of certifier
H. Babaal, MD | | 29c. License number
D46179 | | 29d. Date signed (Month, Day, Year)
Feb. 14, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hossein Babaali 11235 Oak Leaf Dr. #905, Silver Spring, MD 20901 | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
Julia Anderson-Randall | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04471

| | | | | | | | | |
|---|---|--|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
HARTMAN MILLER | | | | 2. Date of Death
Month February Day 15 Year 1997 | | 3. Time of Death
9:07 PM | |
| | 4a. Facility Name (If not institution, give street and number)
Stella Maris Hospice At Mercy Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
214-01-1321 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
85 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 25, 1911 | |
| | 9. Birthplace (State or Foreign Country)
Maryland | | 10a. State
Maryland | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | 10e. Street and Number
1044 Ellicott Drive Way | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: WW II | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Furrier | | 16b. Kind of Business/Industry
Hutzlers | | 17. Father's Name (First, Middle, Last)
Ferdinand Miller | |
| | 18. Mother's Name (First, Middle, Maiden Surname)
Bernadine Kreiger | | 19a. Informant's Name/Relationship (Type, Print)
Mary Ellen Harvey (Daughter) | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1633 Langford Road Baltimore, Maryland 21207 | | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery | | 20c. Date
February 19, 1997 | | 20d. Location - City or Town, State
Baltimore, Maryland | | 21. Signature of Funeral Service Licensee
<i>[Signature]</i> | |
| | 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228 | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Chronic Obstructive Pulmonary Disease | | 23b. Approximate Interval Between Onset and Death
years | | 23c. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| To Be Completed by Physician/Medical Examiner | 23d. Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Pneumonia, BPT, mild dementia | | 23e. Due to (or as a consequence of): | | 23f. Due to (or as a consequence of): | | 23g. Due to (or as a consequence of): | |
| | 23h. Due to (or as a consequence of): | | 23i. Due to (or as a consequence of): | | 23j. Due to (or as a consequence of): | | 23k. Due to (or as a consequence of): | |
| To Be Completed by Physician/Medical Examiner | 24. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 25. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE | | 26. Describe how injury occurred | | 27. Location (Street and Number or Rural Route Number, City or Town, State) | |
| | 28. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 29a. Date of Injury (Month, Day, Year)
February 17, 1997 | | 29b. Time of Injury
M | | 29c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| To Be Completed by Physician/Medical Examiner | 30a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 30b. Signature and title of certifier
<i>[Signature]</i> | | 30c. License number
546480 | | 30d. Date signed (Month, Day, Year)
February 17, 1997 | |
| | 31. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FERNANDO J. FERRARO | | 32. Date filed (Month, Day, Year)
FEB 18 1997 | | 33. Registrar's Signature
<i>[Signature]</i> | | 34. State
Maryland | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97-04472

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GAIL DIANE McCaughey

2. Date of Death
Month Day Year
FEBRUARY 7, 19973. Time of Death
1:00 P.M.

4a. Facility Name (If not institution, give street and number)

2639 SHEPPARD ROAD

4b. City, Town, or Location of Death

MONKTON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

215-50-8220

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

JANUARY 20, 1951

9. Birthplace (State or Foreign
Country)

BALTIMORE, MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

MONKTON

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number

2639 SHEPPARD ROAD

10f. Zip Code

21111

10g. Citizen of What Country?

U.S.A.

11. Marital Status
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: WHITE15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOUSEKEEPING-OWN HOME

17. Father's Name (First, Middle, Last)

DONALD MAXWELL MACE

18. Mother's Name (First, Middle, Maiden Surname)

JEAN C. TOWNSEND

19a. Informant's Name/Relationship (Type, Print)

MICHAEL T. McCAUGHEY (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 575 MONKTON, MARYLAND 21111

20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

LOUON PARK CEMETERY FEBRUARY 11, 1997

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Michael T. McCaughey

22. Name and Address of Facility

LASSAHN FUNERAL HOME, INC.

7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. 38 Cal Pistol Wound To Head

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☒ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)

2/7/97

28b. Time of
injury

1 P M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Placed Pistol in Back of Mouth

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

AT Home

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

2639 Sheppard Rd 21111

29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles F. O'Donnell MD

29c. License number

D-09383

29d. Date signed (Month, Day, Year)

12 April 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell MD - 111 Hamlet Hill Rd Maryland 21240

31. Date filed (Month, Day, Year)

APR 17 1997

32. Registrar's Signature

*John Davidson-Randell*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04473

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marian

2. Date of Death

February 10, 1997

3. Time of Death

2:30 PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

CITY

Funeral
Director

5. Social Security Number

396 07 7508

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 30 1917

9. Birthplace (State or Foreign Country)

NA

Usual Residence of Decedent

10a. State

Maryland

10b. County

CITY

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1017 Valley Street

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

N/A

18. Mother's Name (First, Middle, Maiden Surname)

N/A

19a. Informant's Name/Relationship (Type, Print)

Lilly Thorton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1032 Valley St. Baltimore, MD 21202

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Cemetery Feb 14, 1997 Baltimore City

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Lilly & Zeiler, Inc. Funeral Home
1901 Eastern Ave., Baltimore, MD 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic obstructive Pulmonary disease

Due to (or as a consequence of):

30 years

c. Tobacco abuse

Due to (or as a consequence of):

40 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Poor nutritional status

Acute Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Bart Scott, Johns Hopkins Hospital.

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04474

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH

NATHAN

2. Date of Death

Month Day Year
FEB. 10, 1997

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

8905 ALLENSWOOD ROAD

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

072-18-2652

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 18, 1910

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8905 ALLENSWOOD ROAD

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

PAINTER

16b. Kind of Business/Industry

HOME IMPROVEMENT

17. Father's Name (First, Middle, Last)

LOUIS

18. Mother's Name (First, Middle, Maiden Surname)

HENRIETTA

(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print) (NEPHEW)

J. RONALD SHIFF (ATTY.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

233 E. REDWOOD ST. BALTIMORE, MD 21202

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHEVRA AHAVAS CHESED - 2/13/97 RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause: Final disease or condition resulting in death

a. Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20964

29d. Date signed (Month, Day, Year)

02-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John H. ...

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



AL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04475

Physician
/Medical
Examiner

Funeral
Director

| | | | | | | | |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)
FLORENCE O'DONNELL | | | | 2. Date of Death
Month February Day 16 Year 1997 | | 3. Time of Death
0855 AM | |
| 4a. Facility Name (If not institution, give street and number)
Stella Maris | | | | 4b. City, Town, or Location of Death
Towson | | 4c. County of Death
Baltimore | |
| 5. Social Security Number
212-01-2356 | | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Nov 23, 1912 | |
| 9. Birthplace (State or Foreign Country)
Md | | | | | | | |
| 10a. State
Md | | 10b. County
Baltimore | | 10c. City, Town or Location
Towson | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
8 Edgeclift Road | | | | 10f. Zip Code
21286 | | 10g. Citizen of What Country?
USA | |
| 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: white | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12)
12 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Secretary | | 16b. Kind of Business/Industry
Educational | |
| 17. Father's Name (First, Middle, Last)
Herman Reich | | | | 18. Mother's Name (First, Middle, Maiden Surname)
May (Unknown) | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Thomas J. O'Donnell/Husband | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 Edgeclift Road, Towson, Md 21286 | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Data
2/17 | | 20c. Location - City or Town, State
Beltsville, Md | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bradley Ashton Funeral Home, Inc
2134 Willow Spring Road, Balto, MD 21222 | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one condition on each line.

Immediate Cause (Final disease or condition resulting in death)
a. COLON CANCER, METASTATIC
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28d. Describe how injury occurred | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
Kendall Faulkner | | | | 29c. License number
D25643 | | 29d. Date signed (Month, Day, Year)
2/17/97 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD. TOWSON, MD 21204 | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
 | | | |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

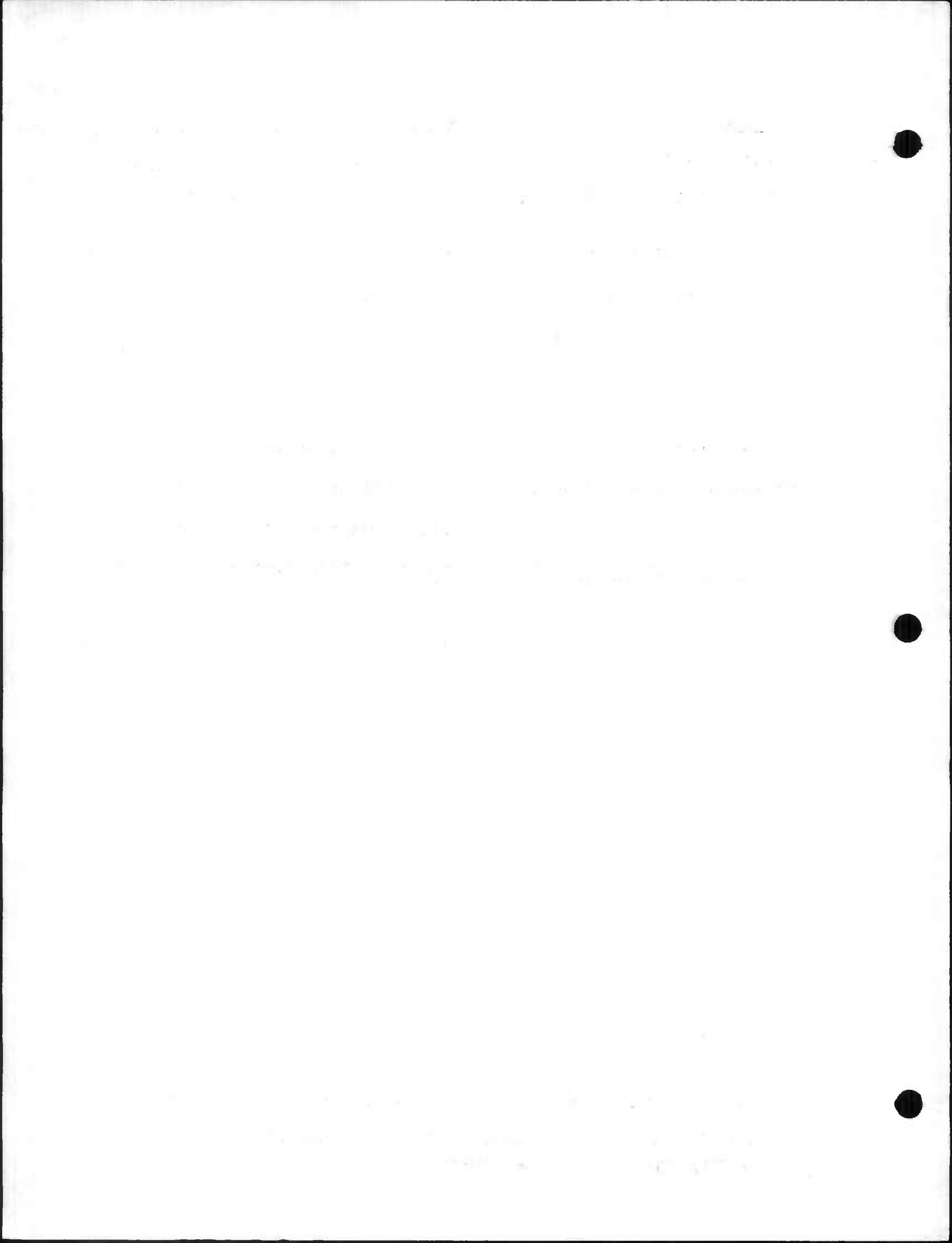
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04476

| | | | | | |
|-------------------------------------|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>Paul Oyier</u> | | 2. Date of Death
Month <u>February</u> Day <u>16</u> Year <u>1997</u> | | 3. Time of Death
<u>0730</u> |
| | 4e. Facility Name (If not institution, give street and number)
<u>SHADY GROVE ADVENTIST HOSPITAL</u> | | 4b. City, Town, or Location of Death
<u>ROCKVILLE</u> | | 4c. County of Death
<u>MONTGOMERY</u> |
| Funeral
Director | 5. Social Security Number
<u>192-76-7911</u> | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>28</u> Yrs. | If Under 1 Year
Months <u> </u> Days <u> </u> | If Under 24 Hrs.
Hours <u> </u> Min. <u> </u> |
| | 8. Date of Birth (Month, Day, Year)
<u>Jan. 29, 1969</u> | | 9. Birthplace (State or Foreign Country)
<u>Nyanza, Kenya</u> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
<u>MD</u> | | 10b. County
<u>Montgomery</u> |
| | 10c. City, Town or Location
<u>Gaithersburg</u> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
<u>24 West Deer Park Rd. Apt. 304</u> | | 10f. Zip Code
<u>20877</u> | | 10g. Citizen of What Country?
<u>Kenya</u> |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <u> </u> College (1-4 or 5+) <u>4 years</u> | | |
| | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Sales</u> | | 16b. Kind of Business/Industry
<u>Toys Are Us</u> | | |
| | 17. Father's Name (First, Middle, Last)
<u>Hillary Oyier</u> | | 18. Mother's Name (First, Middle, Maiden Surname)
<u>Judeth Oyier</u> | | |
| | 19a. Informant's Name/Relationship (Type, Print)
<u>Atieno Hongo</u> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>7808 Polara Place Rockville, MD 20855</u> | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Uguya Cemetery</u> | | 20c. Location - City or Town, State
<u>Fiaye, Kenya</u> |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
<u>W.H. Bacon Funeral Home</u>
<u>3447 14th St., NW Wash., Dc 20010</u> | | |
| Physician
/Medical
Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<u>ACQUIRED IMMUNE DEFICIENCY SYNDROME</u>
Due to (or as a consequence of): | | | | Approximate Interval Between Onset and Death
<u>5 months</u> |
| | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<u>RENAL FAILURE</u>
<u>SEVERE ANEMIA</u>
<u>METABOLIC ACIDOSIS</u> | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation
<input type="checkbox"/> Accident <input type="checkbox"/> Suicide
<input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
 | | 29c. License number
<u>D 28656</u> |
| | 29d. Date signed (Month, Day, Year)
<u>FEBRUARY 16, 1997</u> | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>RAVI PASSI MD, 8609 SECOND AVE, #404 B, SILVER SPRING MD. 20910</u> | | |
| | 31. Date filed (Month, Day, Year)
<u>FEB 18 1997</u> | | 32. Registrar's Signature
 | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To be completed by the attending physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04477

| | | | | | |
|--|--|--|---|--------------------------------|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<i>Frances</i> | | 2. Date of Death
Month <i>February</i> Day <i>16</i> Year <i>97</i> | | 3. Time of Death
<i>04:35 AM</i> |
| | 4e. Facility Name (If not institution, give street and number)
<i>North Arundel Hospital 301 Hospital Dr.</i> | | 4b. City, Town, or Location of Death
<i>Glen Burnie</i> | | 4c. County of Death
<i>Anne Arundel</i> |
| Funeral
Director | 5. Social Security Number
<i>214-20-5540</i> | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
<i>81</i> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
<i>9-6-15</i> | | 9. Birthplace (State or Foreign Country)
<i>md.</i> | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
<i>Md.</i> | | 10b. County
<i>N/A</i> |
| | 10c. City, Town or Location
<i>Baltimore City</i> | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
<i>819 S. Kenwood Avenue</i> | | 10f. Zip Code
<i>21224</i> | | 10g. Citizen of What Country?
<i>U.S.A.</i> |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: <i>White</i> | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) <i>6</i> Collage (1-4 or 5+) <i>N/A</i> | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<i>Housewife</i> |
| | 16b. Kind of Business/Industry
<i>Home maker</i> | | 17. Father's Name (First, Middle, Last)
<i>Casper Dwsianiecki</i> | | 18. Mother's Name (First, Middle, Maiden Surname)
<i>Emma Long</i> |
| | 19a. Informant's Name/Relationship (Type, Print)
<i>JoAnn Earle</i> | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<i>1128 Nottingham Drive 21061</i> | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<i>Sacred Heart of Mary</i> | | 20c. Location - City or Town, State
<i>3/197</i> |
| | 21. Signature of Funeral Service Licensee
<i>Patrick R. Ruff</i> | | 22. Name and Address of Facility
<i>Charles S. Zeiler and Son, INC.
6224 Eastern Ave.
Baltimore, Md. 21224</i> | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<i>Pulmonary Embolism</i> | | | | |
| 23b. Immediate Cause (Final disease or condition resulting in death)
<i>Pulmonary Embolism</i> | | | | | |
| 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
<i>Deep Vein Thrombosis</i> | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
<i>Deep Vein Thrombosis</i> | | | | | |
| 23d. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | | | | |
| 28a. Date of Injury (Month, Day, Year)
<i>Feb 16, 97</i> | | | | | |
| 28b. Time of Injury
<i>M</i> | | | | | |
| 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | |
| 28d. Describe how injury occurred | | | | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| 29a. Certifier
(Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
<i>P.A. Jaydan</i> | | | | | |
| 29c. License number
<i>D 51010</i> | | | | | |
| 29d. Date signed (Month, Day, Year)
<i>Feb, 16, 97</i> | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<i>Muhammad Jaydan, M.D. - North Arundel Hospital</i> | | | | | |
| 31. Date filed (Month, Day, Year)
<i>FEB 18 1997</i> | | | | | |
| 32. Registrar's Signature
<i>[Signature]</i> | | | | | |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04478

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth O'Connor

2. Date of Death

FEBRUARY 13, 1997

3. Time of Death

1245

4a. Facility Name (If not institution, give street and number)

Church Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-09-2082

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 28, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

408 S. Robinson Street

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Martin O'Connor

18. Mother's Name (First, Middle, Maiden Surname)

Nora Brown

19a. Informant's Name/Relationship (Type, Print)

Herman T. Ruth, Jr., nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

645 48th Street, Baltimore, Md. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

2-15-97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Ann S. Matthews

22. Name and Address of Facility

Matthews Funeral Home

3021 Eastern Ave., Baltimore, Md. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

b. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 years

Many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism
Pituitary Adenoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Navarro M.D. Specialist

29c. License number

D40356

29d. Date signed (Month, Day, Year)

FEBRUARY 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WENDY T. NAVARRO, MD.

1004 BROADWAY, BALTIMORE, MARYLAND 21231

31. Date filed (Month, Day, Year)

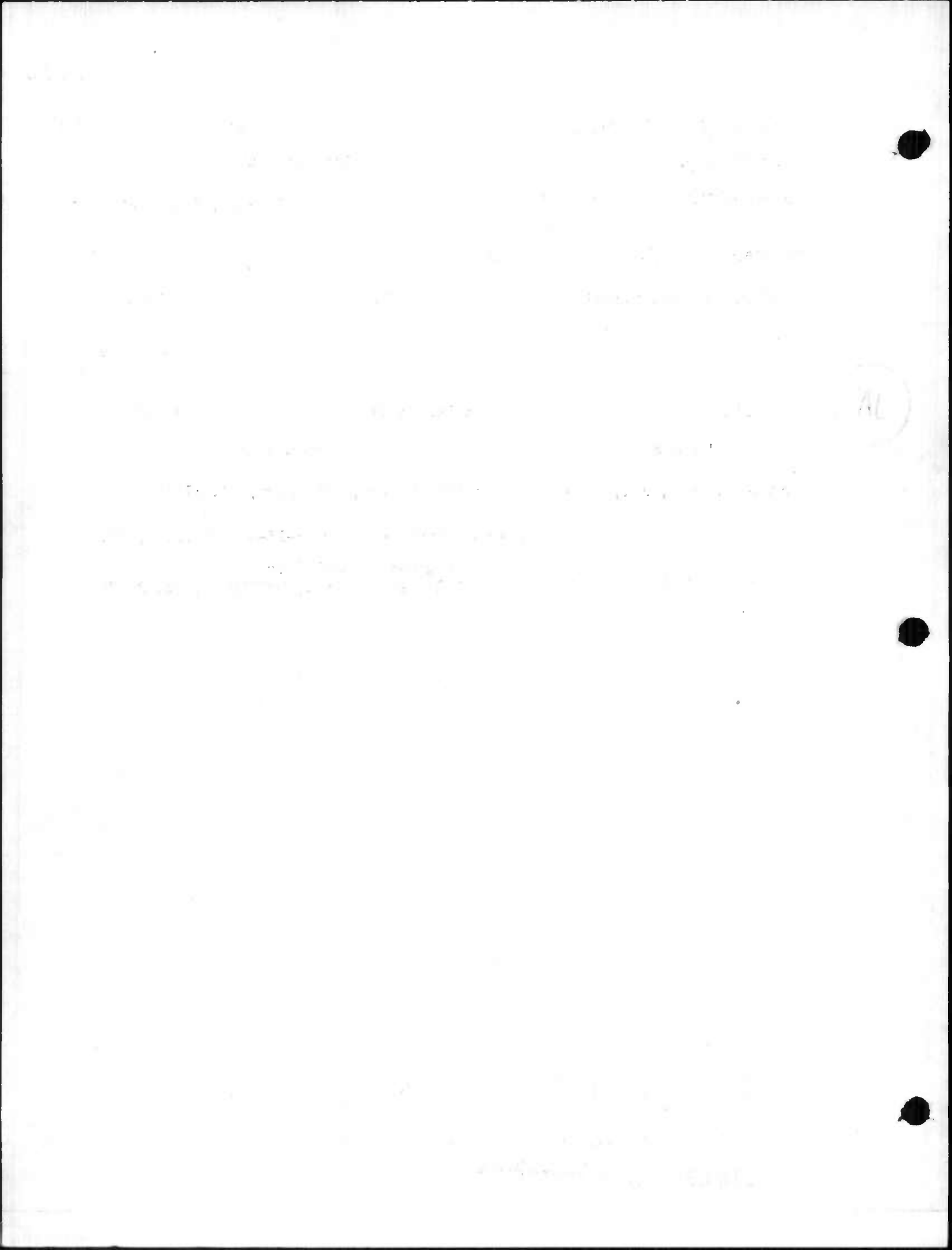
FEB 18 1997

32. Registrar's Signature

Davidson

State
RegistrarBaltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04479

| | | | | | | | |
|--|---|---|---|--|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
John C. O'Mara | | | 2. Date of Death
Month Day Year
February 15 1997 | | 3. Time of Death
11:23 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
719 Maiden Choice Lane | | | 4b. City, Town, or Location of Death
Catonsville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
215-10-4856 | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
91 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
January 12, 1906 | 9. Birthplace (State or Foreign Country)
Maryland |
| | Usual Residence of Decedent | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
Baltimore | 10c. City, Town or Location
Catonsville | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
719 Maiden Choice Lane | | | 10f. Zip Code
21228 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 11 College (1-4or 5+) 11 | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Salesman | | 16b. Kind of Business/Industry
Automotive | | |
| | 17. Father's Name (First, Middle, Last)
Patrick O'Mara | | | 18. Mother's Name (First, Middle, Maiden Surname)
Anne Codd | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Mary O. Seal (Daughter) | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1116 Johnsville Road Sykesville, Maryland 21784 | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Feb. 18, 1997
Crestlawn Memorial Gardens | | 20c. Location - City or Town, State
Marriottsville, Maryland | | |
| | 21. Signature of Funeral Service Licensee
R. Gay Witzke | | | 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Prostate Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | Approximate Interval Between Onset and Death
yes |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury
(Month, Day, Year) | 28b. Time of Injury
M | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | |
| 29b. Signature and title of certifier
[Signature] | | | 29c. License number
124744 | | 29d. Date signed (Month, Day, Year)
February 17, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Andrew Lantz 711 Maiden Choice Lane Catonsville Maryland | | | | | | | |
| State Registrar | 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
[Signature] | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the hospital or attending physician: The law requires that the death certificate be executed within 48 hours after death.

To the funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04480

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|---|---|--|--|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
MAMIE P. PIERCE | | | | 2. Date of Death
Month FEBRUARY Day 17 Year 1997 | | 3. Time of Death
7:30 AM | |
| | 4a. Facility Name (If not institution, give street and number)
Good Samaritan Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
n/a | |
| Funeral
Director | 5. Social Security Number
245 04 4667 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
84 Yrs. | If Under 1 Year
Months | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
July 14, 1912 | | 9. Birthplace (State or Foreign Country)
North Carolina |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Maryland | 10b. County
n/a | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 10e. Street and Number
212 N. Patterson Park Ave | | | 10f. Zip Code
21231 | | 10g. Citizen of What Country?
United States | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 7 College (1-4or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Line Worker | | | 16b. Kind of Business/Industry
Can Factory | | |
| | 17. Father's Name (First, Middle, Last)
John William Porter | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Virginia Carlie Moore | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print)
Robin Riemer / granddaughter | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
330 S. Robinson St., Baltimore, MD 21224 | | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Crematory | | Date
2/19/97 | | 20c. Location - City or Town, State
Baltimore, MD | |
| | 21. Signature of Funeral Service Licensee
 | | | 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286 | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 M.D. | | 29c. License number
D47813 | | 29d. Date signed (Month, Day, Year)
February 18, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BASHAR KARAKASH 3007 E. Northern Parkway Baltimore MD 21214 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04481

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Neil Douglas Phipps

2. Date of Death

February 9 1997

Day

Year

3. Time of Death

5:45 pm

4a. Facility Name (If not institution, give street end number)

1474 Jones Station Road

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

5. Social Security Number

219-32-4370

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 23, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☐ No
unknown

10e. Street end Number

1474 Jones Station Road

10f. Zip Code

21012

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1955-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

18e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home Improvement

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Jefferson Phipps

18. Mother's Name (First, Middle, Maiden Surname)

Helen Elizabeth Stelljies

19a. Informant's Name/Relationship (Type, Print)

Virginia Skinner Phipps/Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

1474 Jones Station Road, Arnold, MD 21012

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

StateAnatomy Board, 655 W. Baltimore Street

Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

pancreatic carcinoma

Approximate Interval Between Onset and Death

13 mos.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Selouick, M.D.

29c. License number

D19838

29d. Date signed (Month, Day, Year)

2/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart E. Selouick, M.D. 900 Bestgate Annapolis, Md. 21401

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04482

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH M REUSS

2. Date of Death
Month Day Year

FEBRUARY 15, 1997 11:05AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

5. Social Security Number

216-20-1347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

OCT 6, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11 Mustone Court

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Teaching Nurse

16b. Kind of Business/Industry

Adult Education

17. Father's Name (First, Middle, Last)

John J. Reuss

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Doble

19a. Informant's Name/Relationship (Type, Print)

John J. Reuss, Jr. / Brother 1310 Angelsea St., Apt. T-2 Baltimore, MD 21224

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc. 02/16/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of Md., Inc.
299 Frederick Road Balto., MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. SUBDURAL HEMATOMA

Due to (or as a consequence of):

5 WEEKS

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

7 YEARS

c. DEMENTIA

Due to (or as a consequence of):

3 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42736

29d. Date signed (Month, Day, Year)

2-15-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AYMAN AKKAD, M.D. 7600 OSLER DRIVE #203 TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filed by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

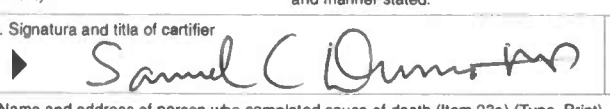

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04483

Certificate of Death

Reg. No.

| | | | | | |
|---|---|--|---|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Catherine D. Roth | | 2. Date of Death
Month February Day 14 Year 1997 | | 3. Time of Death
1:20 AM |
| | 4a. Facility Name (If not institution, give street and number)
8800 Walther Blvd. #1404 | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
Baltimore |
| Funeral
Director | 5. Social Security Number
216 18 9525 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
82 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. |
| | 8. Date of Birth (Month, Day, Year)
Jan. 9, 1915 | | 9. Birthplace (State or Foreign Country)
Maryland | | |
| To Be Completed by Funeral Director | Usual Residence of Decedent | | 10a. State
Maryland | | 10b. County
Baltimore |
| | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
8800 Walther Blvd. #1404 | | 10f. Zip Code
21234 | | 10g. Citizen of What Country?
United States |
| | 11. Marital Status
<input type="checkbox"/> Navar Marriad <input type="checkbox"/> Married
<input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| | 14. Race - American Indian, Black, White, etc.
Specify: White | | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 9 College (1-4 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Clerical Supervisor |
| | 16b. Kind of Business/Industry
Telephone Company | | 17. Father's Name (First, Middle, Last)
George Hesse | | 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Perringer |
| | 19a. Informant's Name/Relationship (Type, Print)
J. Ronald Roth / son | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 E. Pennsylvania Ave., Towson, MD 21286 | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Jesus Cem. 2/17/97 Baltimore, MD | | 20c. Location - City or Town, State |
| | 21. Signature of Funeral Service Licensee
 | | 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Dr., Baltimore, MD 21286 | | |
| | 23a. Part I. Entertain the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | |
| Physician
/Medical
Examiner | Immediate Cause (Final disease or condition resulting in death) | | a. MYELOMA
Due to (or as a consequence of): | | Approximate Interval Between Onset and Death |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | b. CARDIAC ARREST
Due to (or as a consequence of): | | |
| | | | c. RENAL FAILURE
Due to (or as a consequence of): | | |
| | | | d. | | |
| | | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | |
| | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M |
| | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how injury occurred | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | |
| 29b. Signature and title of certifier
 | | 29c. License number
D47040 | | 29d. Date signed (Month, Day, Year)
February 14, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Samuel C. Durso, MD 8800 Walther Blvd., Baltimore, MD 21234 | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04484

| | | | | | | | | |
|--|---|---|--|--|--|--|---|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
WILLIE ROBINSON | | | | 2. Date of Death
Month FEBRUARY Day 11 Year 1997 | | 3. Time of Death
2338PM | |
| | 4a. Facility Name (If not institution, give street and number)
1918 RUXTON AVENUE | | | | 4b. City, Town, or Location of Death
BALTIMORE CITY | | 4c. County of Death
N/A | |
| Funeral
Director | 5. Social Security Number
412-07-9347 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
87 Yrs. | | 8. Date of Birth (Month, Day, Year)
Sept. 5, 1909 | |
| | Usual Residence of Decedent
10a. State Md. 10b. County N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 10e. Street and Number
1918 Ruxton Avenue | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
U.S.A. | | | | |
| 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
If Yes, Give Year or Dates: 1/1944
3/1946 | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th Grade | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Freight Handler | | 16b. Kind of Business/Industry
Kane Transfer Co. | | | | |
| 17. Father's Name (First, Middle, Last)
Richard Robinson | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Nella Hall | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Ethel L. Dixon daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2512 Brookfield Avenue Baltimore, Md. 21217 | | | | |
| 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Md. National Memorial | | 20c. Location - City or Town, State
Feb. 18 Laurel, Md. | | | | |
| 21. Signature of Funeral Service Licensee
<i>Sandy L. Poller</i> | | | | 22. Name and Address of Facility
Nutter Funeral Homes, Inc.
2501 Gwynns Falls PKWY Baltimore, Md. 21216 | | | | |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of): | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | |
| | | | | | | 24a. Was an autopsy performed?
INSPECTION
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 25. Was case referred to medical examiner?
1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<i>Dennis J. Chute</i> | | | | 29c. License number
O.C.M.E. | | 29d. Date signed (Month, Day, Year)
FEBRUARY 12, 1997 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Signature of Registrar
<i>John F. ...</i> | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04485

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JULIA M. RODENBERG

2. Date of Death

Month Day Year
FEBRUARY 15, 1997

3. Time of Death

9:35 pm

4a. Facility Name (If not institution, give street and number)

IVY HALL GERIATRIC CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

212364085

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
FEB. 28, 1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ROSEDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7935 DALROSE AVE

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (14 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHN DORN

18. Mother's Name (First, Middle, Maiden Surname)

SOPHIE unk.

19a. Informant's Name/Relationship (Type, Print)

MARY HORST / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7935 DALROSE AVENUE ROSEDALE, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLY HILLS

Date

2/18

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME
1211 CHESACO AVE 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SARINDER K TULLA 2 Market Place Baltimore MD 21222

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

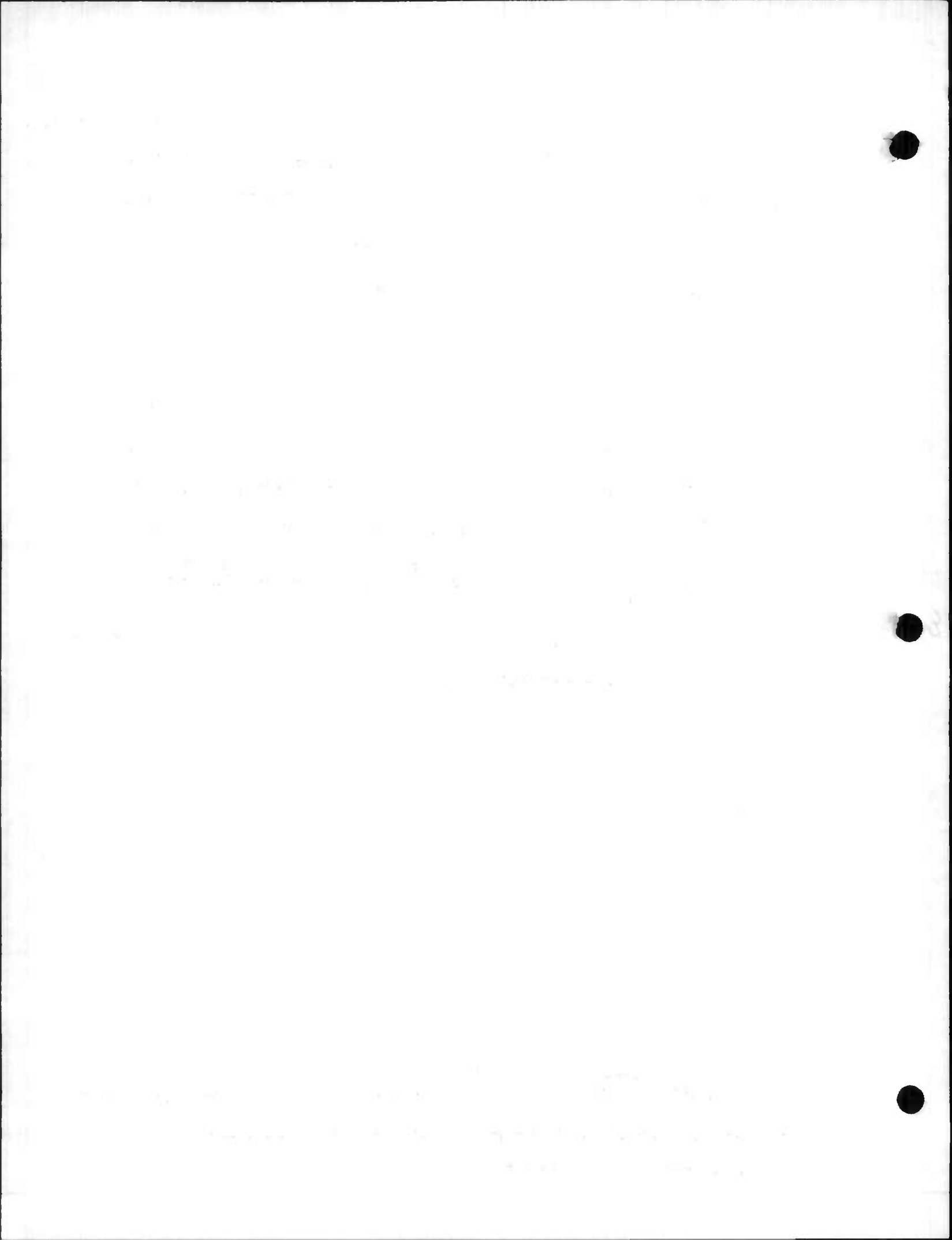
97 04486

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Chaddie RAMSEY | | | | 2. Date of Death
Month Day Year
February 14, 1997 | | 3. Time of Death
1:30 A.M. | |
| | 4a. Facility Name (If not institution, give street and number)
Franklin Square Hospital Center | | | | 4b. City, Town, or Location of Death
Rossville | | 4c. County of Death
Baltimore | |
| Funeral
Director | 5. Social Security Number
408-54-5927 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
61 Yrs. | | 8. Date of Birth (Month, Day, Year)
Jan. 18, 1936 | |
| | 9. Birthplace (State or Foreign Country)
Tennessee | | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Essex | |
| To Be Completed by Funeral Director | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 10e. Street and Number
1 Brett Court | | 10f. Zip Code
21221 | | 10g. Citizen of What Country?
USA | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | | 12. Was Decedent Ever In U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 3rd College (14 or 5+) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Mechanic | | 16b. Kind of Business/Industry
Hydrolic | | | |
| | 17. Father's Name (First, Middle, Last)
Joseph J. Ramsey | | | | 18. Mother's Name (First, Middle, Maiden Surname)
William Emma Massengil | | | |
| | 19a. Informant's Name/Relationship (Type, Print)
Doris Leake / daughter | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Days End Court Balitmore Md. 21237 | | | |
| | 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 2/15/97 | | 20c. Location - City or Town, State
Balitmore Md. | | | |
| | 21. Signature of Funeral Service Licensee
R. Terry Connelly | | 22. Name and Address of Facility
Connelly Funeral Home of Essex
300 MACE AVE. BALTIMORE MD. 21221 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Hypoxemia
Due to (or as a consequence of):
b. Cardiomyopathy ischemic
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d. | | Approximate Interval Between Onset and Death
5 minutes | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | |
| | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| | 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | 28d. Describe how Injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | |
| | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| | 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | 29b. Signature and title of certifier
John Kim | | 29c. License number
R D 1917 | | 29d. Date signed (Month, Day, Year)
February 14, 1997 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. John Kim 9000 Franklin Square Dr. Baltimore, Maryland 21237 | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
John Kim | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04487

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD

RACKMALES

2. Date of Death

FEB 15,

Day Year

1997

3. Time of Death

9:35 AM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212-01-1528

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

3/18/10

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1638 BURNWOOD ROAD

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SERVICE STATION ATTENDANT

16b. Kind of Business/Industry

SERVICE STATION

17. Father's Name (First, Middle, Last)

SANUEL RACKMALES

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE CIV

19a. Informant's Name/Relationship (Type, Print)

ETHEL C. RACKMALES

WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1638 BURNWOOD ROAD BALTIMORE, MD 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST VET. CEM. 2/18/97 OWINGS MILLS, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.

TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. CONGESTIVE HEART FAILURE

2 DAYS

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

2 DAYS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.A.

29c. License number

P10582

29d. Date signed (Month, Day, Year)

FEB 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANN MECHERIKUNNEL, 5601 LOCH RAVEN BLVD, BALTIMORE, MD - 21239

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Jana Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04488

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Beatrice Ritz

2. Date of Death

February 10 1997

Day

Year

3. Time of Death

4:30 p

4a. Facility Name (If not institution, give street and number)

Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

CITY

5. Social Security Number

216-54-1152

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 30, 1940

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CITY

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

259 S. HIGHLAND AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARM GRAY

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE SIZEMORE

19a. Informant's Name/Relationship (Type, Print)

ROBERT RITZ/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

259 S. HIGHLAND AVENUE BALTIMORE, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VA CEM 2/14/97

Date

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

Elizabeth Selinski

22. Name and Address of Facility

Lilly & Zeiler, Inc. Funeral Homes
700 S. Conkling Street Baltimore, MD 21224

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3-4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Neutropenia
Due to (or as a consequence of):

3-4 days

c. Metastatic Small Cell Carcinoma
Due to (or as a consequence of):

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Claudia Claiborne

29c. License number

96704

29d. Date signed (Month, Day, Year)

February 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Claudia Claiborne Bayview Medical Center

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Driscoll

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04489

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
<u>RUFUS SMITH</u> | | | | 2. Date of Death
Month <u>FEB</u> Day <u>8</u> Year <u>97</u> | | 3. Time of Death
<u>11:30 PM</u> | |
| | 4a. Facility Name (If not institution, give street and number)
<u>Bon Secours Hospital</u> | | | | 4b. City, Town, or Location of Death
<u>Baltimore</u> | | 4c. County of Death
<u>N/A</u> | |
| Funeral
Director | 5. Social Security Number
<u>239-20-1057</u> | | 8. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
<u>80</u> Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 6. Date of Birth (Month, Day, Year)
<u>May 15, 1916</u> | 9. Birthplace (State or Foreign Country)
<u>N.C.</u> |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
<u>Md.</u> | | 10b. County
<u>N/A</u> | | 10c. City, Town or Location
<u>Baltimore</u> | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10e. Street and Number
<u>2309 Ellamont Street</u> | | | | 10f. Zip Code
<u>21216</u> | | 10g. Citizen of What Country?
<u>U.S.A.</u> | |
| | 11. Marital Status
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: <u>Black</u> | |
| | 15. Decedent's Education (Specify only highest grade completed)
<u>Elementary/Secondary (0-12)</u> <u>College (1-4or 5+)</u>
<u>7th Grade</u> | | | | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
<u>Laborer</u> | | 16b. Kind of Business/Industry
<u>Bethlehem Steel Corp.</u> | |
| | 17. Father's Name (First, Middle, Last)
<u>Thomas Smith</u> | | | | 18. Mother's Name (First, Middle, Maiden Surname) | | | |
| Physician
/Medical
Examiner | 19a. Informant's Name/Relationship (Type, Print) <u>wife</u>
<u>Beryl Smith</u> | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
<u>2309 Ellamont Street Baltimore, Md. 21216</u> | | | |
| | 20a. Method of Disposition
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
<u>Woodlawn Cemetery</u> | | Date
<u>Feb. 15</u> | | 20c. Location - City or Town, State
<u>Woodlawn, Md.</u> | |
| | 21. Signature of Funeral Service Licensee
<u>James L. Rollins</u> | | | | 22. Name and Address of Facility
<u>Nutter Funeral Homes, Inc.</u>
<u>2501 Gwynns Falls PKWY Baltimore, Md. 21216</u> | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
<u>CARDIAC ARREST</u>
Due to (or as a consequence of):
<u>CONGESTIVE HEART FAILURE</u>
Due to (or as a consequence of):
<u>RENAL FAILURE</u>
Due to (or as a consequence of):
<u>ATHEROSCLEROSIS</u> | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | | | | | |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | | | | |
| | 24b. Were autopsy findings available prior to completion of cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | | | | | | | |
| | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
<u>M</u> | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | |
| 29b. Signature and title of certifier
<u>Wm. J. Smith</u> | | | | 29c. License number
<u>D24148</u> | | 29d. Date signed (Month, Day, Year)
<u>2-9-97</u> | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
<u>Wm. J. Smith MD 3502 W ROBERT AVE A6 Baltimore 21215</u> | | | | | | | | |
| 31. Date filed (Month, Day, Year)
<u>FEB 18 1997</u> | | | | 32. Registrar's Signature
<u>John R. Riddle</u> | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 04490

Reg. No.

| | | | | | | | | |
|--|---|--|---|--|---|--------------------------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
DOROTHY I. SNOW | | | | 2. Date of Death
Month Day Year
FEBRUARY 13 1997 | | 3. Time of Death
11-55PM | |
| | 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL | | | | 4b. City, Town, or Location of Death
GLENBURNIE | | 4c. County of Death
ANNE ARUNDEL | |
| Funeral
Director | 5. Social Security Number
213-32-7643 | | 6. Sex
1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
61 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
Aug. 1, 1935 | 9. Birthplace (State or Foreign Country)
N. Carolina |
| | Usual Residence of Decedent | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
Md. | | 10b. County
Baltimore | | 10c. City, Town or Location
Dundalk | | 10d. Inside City Limits
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 10e. Street and Number
1938 Cedar Lane | | | | 10f. Zip Code
21222 | | 10g. Citizen of What Country?
U.S.A. | |
| | 11. Marital Status
1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: White | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 8th College (1-4or 5+) | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Homemaker | | 16b. Kind of Business/Industry
Own Home | |
| | 17. Father's Name (First, Middle, Last)
Talmadge Allen | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Grace Phipps | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Michael Snow/Son | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1938 Cedar Lane, Baltimore, Md. 21222 | | | |
| | 20a. Method of Disposition
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory | | Date
2-17-97 | | 20c. Location - City or Town, State
Beltsville, Md. | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Bradley-Ashton Funeral Home, Inc.
2134 Willow Spring Rd., Balto., Md. 21222 | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
PNEUMONIA

Due to (or as a consequence of):
METASTATIC LUNG CANCER

Approximate Interval Between Onset and Death
5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
3 MONTHS | | | | | | | |
| | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | |
| State Registrar | 25. Was case referred to medical examiner?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | | | | 26. Place of Death (Check only one)
Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) | | | |
| | 27. Manner of Death
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how injury occurred | | | |
| | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | 28b. Did tobacco use contribute to the cause of death?
1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown | | | |
| | 29a. Certifier (Check only one)
1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | 29b. Signature and title of certifier
 | | | |
| 29c. License number
D 46962 | | | | 29d. Date signed (Month, Day, Year)
FEBRUARY 13, 1997. | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M. SHIRAZI, M.D. HOUSE STAFF. NORTH ARUNDEL HOSPITAL. MD 21061. | | | | | | | | |
| 31. Date of Death (Month, Day, Year)
FEB 18 1997 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04491

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS Smith

2. Date of Death

Month

Day

Year

February 12, 1997

3. Time of Death

7:45 PM

4a. Facility Name (If not institution, give street and number)

St. Elizabeth Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

212 10 5341

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 8, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

413 E. Hillcrest Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

Montgomery Wards

17. Father's Name (First, Middle, Last)

Ernest Boehlein

18. Mother's Name (First, Middle, Maiden Surname)

Nora Ray

19a. Informant's Name/Relationship (Type, Print)

John Smith / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 E. Hillcrest Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Pk.

Date

2/15/97

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Jerome Zamoski

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE PULMONARY EDEMA

7 Hours

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

7 Hours

Due to (or as a consequence of):

c. TYPE II DIABETES MELLITUS

10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William M. Russell MD

29c. License number

D30182

29d. Date signed (Month, Day, Year)

February 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Russell MD 3320 BENSON AVE BALTIMORE MD 21227

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04492

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY W.

SIEGERT

2. Date of Death

FEBRUARY 12, 1997

Month Day Year

3. Time of Death

4:25PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL

HOSPITAL ASSN

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

212 18 4383

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 4, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

627 Sandy Hill Road

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbers Union

17. Father's Name (First, Middle, Last)

Oscar F. Siegert

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Phipps

19a. Informant's Name/Relationship (Type, Print)

Betty Henderson / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Brookfield Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

2/17/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypertensive Arterio Sclerotic Cardio Vascular Dm

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sick Sinus Syndrome with Pacemaker implant

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D42820

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher de Borja

3708 Mountain Rd, Pasadena Md. 21122

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To be completed by the attending physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit certificate filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the paper is devoted to a general discussion of the problem.

2. In the second part, we consider the case of a single particle.

3. The third part is devoted to the case of a system of particles.

4. In the fourth part, we consider the case of a continuous medium.

5. The fifth part is devoted to the case of a system of continuous media.

6. In the sixth part, we consider the case of a system of continuous media.

7. The seventh part is devoted to the case of a system of continuous media.

8. In the eighth part, we consider the case of a system of continuous media.

9. The ninth part is devoted to the case of a system of continuous media.


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

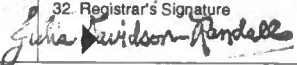
97 04493

Certificate of Death

Reg. No.

| | | | | | | | | |
|--|--|---|--|--|---|---|--|---|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
Belinda C. Smith | | | | 2. Date of Death
Month Feb Day 13 Year 1997 | | 3. Time of Death
1600 pm | |
| | 4a. Facility Name (If not institution, give street and number)
Deaton Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
None | |
| Funeral
Director | 5. Social Security Number
219-78-7142 | 6. Sex
<input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)
37 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth (Month, Day, Year)
May 12, 1959 | | 9. Birthplace (State or Foreign Country)
Md |
| | Usual Residence of Decedent | | | | | | | |
| 10a. State
Maryland | | 10b. County
None | | 10c. City, Town or Location
Baltimore | | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10e. Street and Number
4023 Duvall Ave. | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | | |
| 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | |
| 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1 | | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Photo Printer | | 16b. Kind of Business/Industry
Segal Majestic | | |
| 17. Father's Name (First, Middle, Last)
Cearney Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hannah Parran | | | | |
| 19a. Informant's Name/Relationship (Type, Print)
Angela Smith / Sister | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4023 Duvall Ave. Baltimore, Maryland 21216 | | | | |
| 20a. Method of Disposition
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory | | Date
1-17 | | 20c. Location - City or Town, State
Baltimore, Maryland | | |
| 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
The Derrick C. Jones Funeral Home
4611 Park Heights Ave. Baltimore, Maryland 21215 | | | | |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
SEPSIS
Due to (or as a consequence of):
BILATERAL PNEUMONIA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
QUADRA PLEGIA
Due to (or as a consequence of):

Approximate Interval Between Onset and Death
3 Weeks
10 Weeks
6 Years | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
OSTEOMYELITIS @ Hip / Decubitus Ulcer
FUNGEMIA : CHRONIC ANAEMIA | | | | | | | | |
| 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | |
| 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | |
| 29b. Signature and title of certifier
JAMES P.G. FLYNN MD. | | | | 29c. License number
DO 1346 | | 29d. Date signed (Month, Day, Year)
Feb 13 1997 | | |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
JAMES P.G. FLYNN MD DEATON SPECIALTY HOSPITAL, 615 CHARLES ST BALTIMORE | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04494

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BESSIE

K.

SAUBER

2. Date of Death

FEB. 15, 1997

3. Time of Death

7:58 AM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

7503 PARK HEIGHTS AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

220-22-8290

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 14, 1900

9. Birthplace (State or Foreign Country)

MASS.

Usual Residence of Decedent

10e. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7503 PARK HEIGHTS AVE.

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES PERSON

16b. Kind of Business/Industry

HUTZLER'S DEPT. STORE

17. Father's Name (First, Middle, Last)

ABRAHAM DAVID KERNER

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

ROSALIE S. SAUBER (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3737 CLARKS LANE, BALTIMORE, MD 21215

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH TFILOH CONG

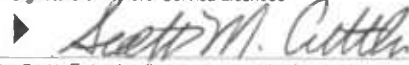
Date

2-16-97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN RD; PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiac arrest*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *ASCVD*
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe O.B.S.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier



29c. License number

D1C941

29d. Date signed (Month, Day, Year)

2/15/97

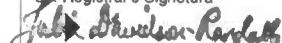
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21 Crossroad Drive Owings Mills, Md 21117

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

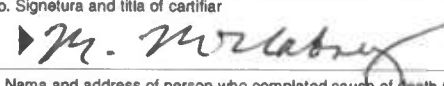
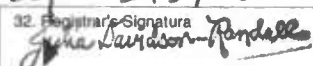
Certificate of Death

97 04495

Reg. No.

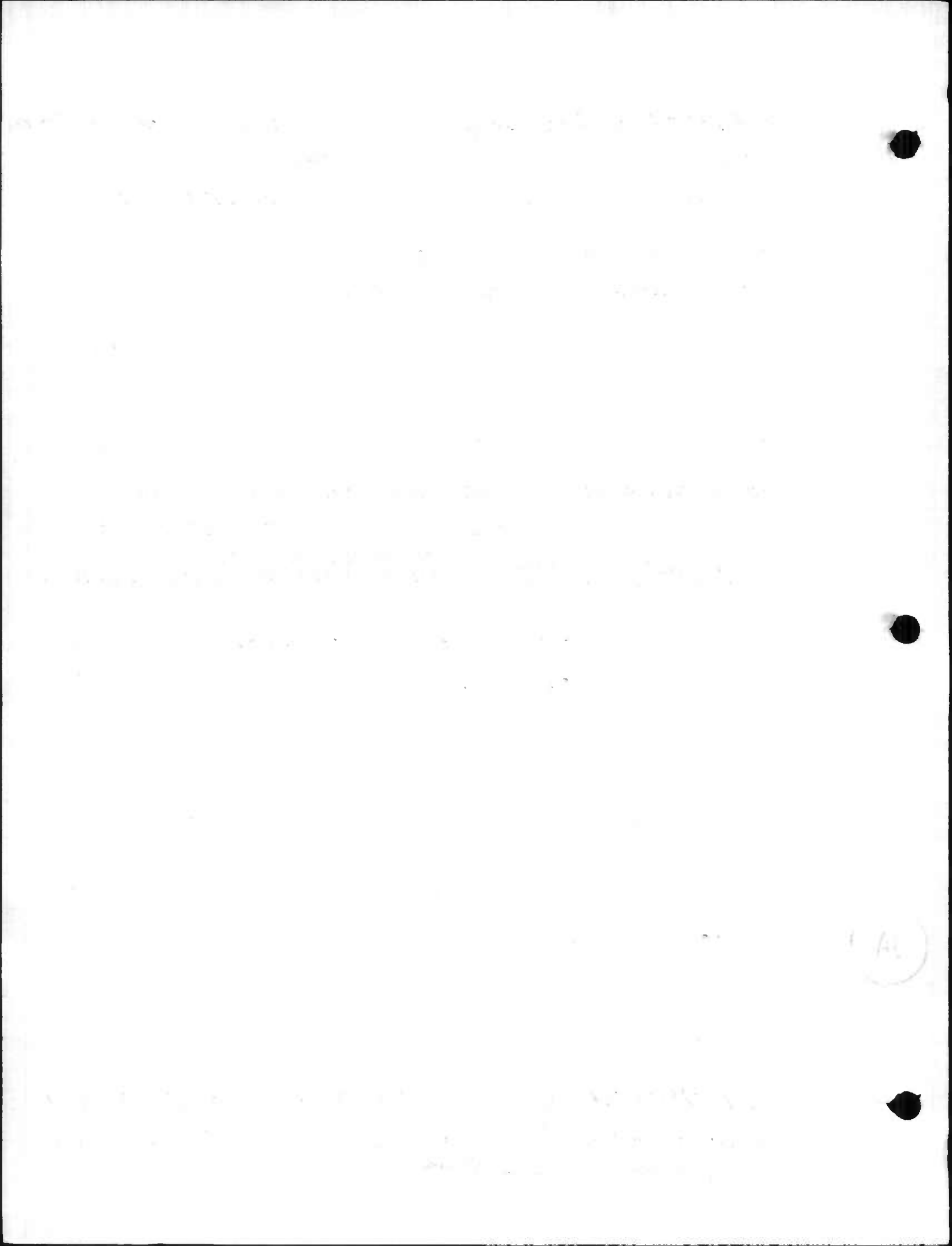
| | | | | | | | | | | | |
|--|---|--|---|--|--|---|---|---|--|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
CHARLES L. SOLOMON | | | | | | 2. Date of Death
Month FEB Day 14 Year 1997 | | 3. Time of Death
6:50 PM | | |
| | 4a. Facility Name (If not institution, give street and number)
LEVINDALE | | | | | | 4b. City, Town, or Location of Death
BALTIMORE | | 4c. County of Death
N/A | | |
| Funeral
Director | 5. Social Security Number
216-44-2602 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | | 7. Age (In yrs. last birthday)
91 Yrs. | | 8. Date of Birth (Month, Day, Year)
FEB. 1, 1906 | | 9. Birthplace (State or Foreign Country)
MARYLAND | | |
| | Usual Residence of Decedent | | | | | | | | | | |
| To Be Completed by Funeral Director | 10a. State
MD | | 10b. County
BALTIMORE | | 10c. City, Town or Location
BALTIMORE | | | | 10d. Inside City Limits
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | |
| | 10e. Street and Number
7202 VALLEY COUNTRY CT., APT. B-3 | | | | 10f. Zip Code
21208 | | 10g. Citizen of What Country?
USA | | | | |
| | 11. Marital Status
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | | 14. Race - American Indian, Black, White, etc.
Specify: WHITE | | | |
| | 15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 4 College (1-4 or 5+) | | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
ATTORNEY | | | 16b. Kind of Business/Industry
AT LAW | | | | |
| | 17. Father's Name (First, Middle, Last)
DAVID SOLOMON | | | | 18. Mother's Name (First, Middle, Maiden Surname)
ANNA LEVY | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
MERRILL LEVY (NEPHEW) | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5906 EASTCLIFF DR. BALTO., MD 21209 | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place)
SHAAREI TFILOH | | Data
2/17/97 | | 20c. Location - City or Town, State
BALTIMORE, MD | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
SOL LEVINSON & BROS., INC.
8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPTIC DECUBITUS ULCER
Due to (or as a consequence of):
b. DEMENTIA
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | |
| | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 24a. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 24b. Were autopsy findings available prior to completion of cause of death?
NA
<input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | 28d. Describe how Injury occurred | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | 29b. Signature and title of certifier
 | | 29c. License number
D45757 | | 29d. Date signed (Month, Day, Year)
FEB 17, 1997 | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MATTHEW MCINTYRE 2434 W Belvedere Balt, MD 21215 | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | 32. Registrar's Signature
 | | | | | | | | | |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04496

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN

SAPERO

2. Date of Death
Month Day Year
FEBRUARY 16, 19973. Time of Death
1:15 AM

4a. Facility Name (If not institution, give street and number)

7 Slade Ave Apt 603

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

219-22-5475

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 9, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 Slade Ave. Apt 603

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Nathan

Feldman

18. Mother's Name (First, Middle, Maiden Surname)

Yetta

Unknown

19a. Informant's Name/Relationship (Type, Print)

Mrs Phyllis Fink (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Hamlet Hill Rd Apt 1104, Baltimore, MD 21210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Hebrew

Date

2/17/97

20c. Location - City or Town, State

Reisterstown, MD

21. Signature of Funeral Service Licensee

Scott M. Cutler

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Anemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Myelodysplasia

Due to (or as a consequence of):

9 months

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

hypertension

diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marvin J. Feldman MD

29c. License number

D07930

29d. Date signed (Month, Day, Year)

February 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARVIN J. FELDMAN, MD

301 St. Paul Place Baltimore, Md 21204

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

Jane Davidson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04497

Certificate of Death

Reg. No.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|---|------------------|---|----------------------------------|--|---------------------------------|----------------|----------------------------------|--|--|-------------------------|----------------|----------------------------------|--|--|----------------|--------------|--|--|
| Physician
/Medical
Examiner | 1. Decedent's Name (First, Middle, Last)
LESTER K SMITH | | | | 2. Date of Death
Month FEBRUARY Day 14 Year 1997 | | 3. Time of Death
7:50 PM | | | | | | | | | | | | | | | | | | | | |
| | 4a. Facility Name (If not institution, give street and number)
University Hospital | | | | 4b. City, Town, or Location of Death
Baltimore | | 4c. County of Death
N/A | | | | | | | | | | | | | | | | | | | | |
| Funeral
Director | 5. Social Security Number
220-76-4909 | | 6. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)
39 Yrs. | If Under 1 Year
Months Days | If Under 24 Hrs.
Hours Min. | 8. Date of Birth
(Month, Day, Year)
07-28-57 | 9. Birthplace (State or Foreign Country)
MD | | | | | | | | | | | | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Funeral Director | 10e. State
MD | | 10b. County
N/A | | 10c. City, Town or Location
Baltimore | | 10d. Inside City Limits
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | |
| | 10e. Street and Number
2821 W. Lanvale Street | | | | 10f. Zip Code
21216 | | 10g. Citizen of What Country?
USA | | | | | | | | | | | | | | | | | | | | |
| | 11. Marital Status
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 12. Was Decedent Ever in U.S. Armed Forces?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | | 14. Race - American Indian, Black, White, etc.
Specify: Black | | | | | | | | | | | | | | | | | | | | |
| | 15. Decedent's Education
(Specify only highest grade completed)
Elementary/Secondary (0-12) 9th College (1-4or 5+) N/A | | 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Press Operator | | 16b. Kind of Business/Industry
Victory Graphic | | | | | | | | | | | | | | | | | | | | | | |
| | 17. Father's Name (First, Middle, Last)
Leslie Smith | | | | 18. Mother's Name (First, Middle, Maiden Surname)
Hilda Hooper | | | | | | | | | | | | | | | | | | | | | | |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)
Michelle B. Hooper | | | | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2821 W. Lanvale St. Baltimore, MD 21216 | | | | | | | | | | | | | | | | | | | | | | |
| | 20a. Method of Disposition
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | | 20b. Place of Disposition (Name of cemetery, crematory or other place).
Western Star Cemetery | | 20c. Location - City or Town, State
Catonsville, MD. | | 20d. Date
2/19/97 | | | | | | | | | | | | | | | | | | | | |
| | 21. Signature of Funeral Service Licensee
 | | | | 22. Name and Address of Facility
Albert P. Wylie Funeral Home P.A. 638 N. Gilman St. 21217 | | | | | | | | | | | | | | | | | | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. SEPSIS</td> <td>Approximate Interval Between Onset and Death
2 DAYS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>f. CRYPTOCOCCUS FUNGEMIA</td> <td>10 DAYS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>g. RENAL FAILURE</td> <td>10 DAYS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td></td> <td>h. AIDS</td> <td>YEARS</td> </tr> <tr> <td colspan="2"></td> <td></td> </tr> </table> | | | | | | | | Immediate Cause (Final disease or condition resulting in death) | e. SEPSIS | Approximate Interval Between Onset and Death
2 DAYS | Due to (or as a consequence of): | | f. CRYPTOCOCCUS FUNGEMIA | 10 DAYS | Due to (or as a consequence of): | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | g. RENAL FAILURE | 10 DAYS | Due to (or as a consequence of): | | | h. AIDS | YEARS | | |
| Immediate Cause (Final disease or condition resulting in death) | e. SEPSIS | Approximate Interval Between Onset and Death
2 DAYS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | f. CRYPTOCOCCUS FUNGEMIA | 10 DAYS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | g. RENAL FAILURE | 10 DAYS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | h. AIDS | YEARS | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | 23b. Did tobacco use contribute to the cause of death?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24e. Was an autopsy performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | 24b. Were autopsy findings available prior to completion of cause of death?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| 25. Was case referred to medical examiner?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | 26. Place of Death (Check only one)
Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 27. Manner of Death
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide
<input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | | 28a. Date of Injury (Month, Day, Year) | | 28b. Time of Injury
M | | 28c. Injury at Work?
<input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | |
| | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28d. Describe how Injury occurred | | | | | | | | | | | | | | | | | | | | | |
| | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29a. Certifier (Check only one)
<input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
<input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 29b. Signature and title of certifier
 | | | | 29c. License number
RES000 | | 29d. Date signed (Month, Day, Year)
February 14, 1997 | | | | | | | | | | | | | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michelle A. Juaneza 22 S. Greene St. Balto. MD 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31. Date filed (Month, Day, Year)
FEB 18 1997 | | | | 32. Registrar's Signature
 | | | | | | | | | | | | | | | | | | | | | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The few requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. The first part of the paper is devoted to a study of the properties of the function $f(x)$ defined by the equation

$$f(x) = \int_0^x \frac{1}{1+t^2} dt$$

It is shown that the function $f(x)$ is continuous and differentiable on the interval $(-\infty, \infty)$ and that its derivative is given by the formula

$$f'(x) = \frac{1}{1+x^2}$$

$$f(0) = 0$$

$$f(x) = \arctan x$$

The second part of the paper is devoted to a study of the properties of the function $g(x)$ defined by the equation

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04498

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR A. SALTMARSH

2. Date of Death
Month Day Year

2 14 97

3. Time of Death

8:30 PM

4a. Facility Name (If not institution, give street and number)

NORTHAMPTON MANOR

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

Frederick

5. Social Security Number

012-24-1659

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Dec. 20, 1929

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Walkersville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

320 Silver Crest Drive

10f. Zip Code

21793

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales Representative

16b. Kind of Business/Industry

Oil Company

17. Father's Name (First, Middle, Last)

Robert Cotton Saltmarsh

18. Mother's Name (First, Middle, Maiden Surname)

Edna Helen Stoessel

19a. Informant's Name/Relationship (Type, Print)

Mrs. Betty Louise Saltmarsh (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 Silver Crest Dr. Walkersville, MD 21793

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Serv. 2/15/97 Hampstead, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Brian D. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

LIVER FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

UNK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

RENAL FAILURE

Due to (or as a consequence of):

UNK.

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D26499

29d. Date signed (Month, Day, Year)

2-15-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ronna Haight 4 Calvary Dr. Mt Airy MD 21771

31. Date of Death (Month, Day, Year)

FEB 18 1997

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 04499

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Garlen E. Smith

2. Date of Death

Month Day Year
Feb. 10 1997

3. Time of Death

4:15 a.m.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

7293 Pommel Drive

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

213-24-9535

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Apr. 9, 1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10e. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7293 Pommel Drive

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Policeman

16b. Kind of Business/Industry

Law Enforcement

17. Father's Name (First, Middle, Last)

James Thomas Smith

18. Mother's Name (First, Middle, Maiden Surname)

Artie Mae Killen

19a. Informant's Name/Relationship (Type, Print)

Mrs. Phyllis Abicht (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4310 Ridge Avenue, Baltimore, MD 21227

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crestlawn Mem. Gardens

Date

2/13/97

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

Brian L. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)
Eldersburg, MD 21784 (410)-795-1400

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Non Small Cell Lung Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage COPD-Emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, school, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37949

29d. Date signed (Month, Day, Year)

2-11-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Phyllis Abicht, 4310 Ridge Avenue, Baltimore, MD 21227

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Registrar's Signature

John Carson-Randall

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 04500

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WILLY A. STEVENS

2. Date of Death

Month Day Year
02 -12 -1997

3. Time of Death

3:00 am

4a. Facility Name (If not institution, give street and number)

4902 CROWSON AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

223-34-7478

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
04-19-1925

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4902 CROWSON AVE.

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8YRS.

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

INSPECTOR

16b. Kind of Business/Industry

GENERAL MOTORS

17. Father's Name (First, Middle, Last)

NOLAN R. STEVENS

18. Mother's Name (First, Middle, Maiden Surname)

BLANCHE KATE

19a. Informant's Name/Relationship (Type, Print)

MARIE HAFENMAIR (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4902 CROWSON AVE. BALTO., MD. 21212.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GREEN MOUNT CREMATORY 2/14/97 BALTO., MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William R. Parra

22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cardiac arrest

Due to (or as a consequence of):

b. Myocardial Infarction

Due to (or as a consequence of):

c. A.S. (V.D.)

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia treated on 5/14/96 for

a heart block. Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William E. Parra

29c. License number

002966

29d. Date signed (Month, Day, Year)

2/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CELIAR E. PARRA M.D. 3007 EAST NORTHERN PARKWAY BALTO., MD.

31. Date filed (Month, Day, Year)

FEB 18 1997

32. Signature of Registrar

▶

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed
within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

